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SOME STATE AND FEDERAL PERSPECTIVES ON MEDICAID

(Selected papers on the Medicaid
Program, 1976-78)

A cooperative effort of
The National Conference of State Legislatures
and
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The viewpoints and ideas expressed in these pages are those of the authors and do not necessarily represent official policy of the Department of Health, Education, and Welfare or its agencies. Because we believe this material will contribute to an informed dialogue on health care issues, and enhance understanding of the Medicaid program, we have joined in a cooperative endeavor with the National Conference of State Legislatures to share these materials with others.

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FOREWORD

The National Conference of State Legislatures and the Medicaid/Medicare Management Institute are pleased to present State and Federal Perspectives on Medicaid. The problem of containing Medicaid costs has been identified by most State legislatures as a chief priority during recent legislative sessions. Consequently, it is critical that the experiences and policies of those States that have achieved a measure of success in controlling Medicaid costs and in managing their programs effectively be highlighted to benefit other States. This publication underscores the fact that some of the most innovative approaches to health care cost containment have been initiated at the State level.

It is our hope that this publication will be useful for State legislators, staff Medicaid program managers and others concerned with the provision of health care to low income individuals.

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PREFACE

During 1976 and 1977 the National Conference of State Legislatures (NCSL), with the cooperation and assistance of the Medicaid Bureau within the Health Care Financing Administration, HEW, sponsored four separate conferences on the general themes of improving the State legislative role for oversight of the Medicaid program and controlling Medicaid costs.

State and Federal officials involved with various aspects of the Medicaid program were invited to discuss their responsibilities and ideas with the participating State legislators. Panels focused on such issues as management and administration, innovations in cost containment and health care regulatory approaches. Also, some speakers were asked to present broad perspective papers such as the relationship of Medicaid to the entire health care system and the lessons of Medicaid for national health insurance.

This publication is a synopsis of the major presentations at the four conferences and represents an effort by the NCSL and the Medicaid/Medicare Management Institute to share with a wider audience the major concepts and ideas discussed. In addition, some previously published material of pertinence has been included.

When any lengthy presentation is reduced to a few pages, much descriptive material must be deleted. However, every effort was made not only to select the major points made by each speaker, but also to retain the author's style and phrasing as well. Readers are reminded that these presentations were made over the course of nearly two years. Consequently, the observations in them reflect the health care debate at that time; more recent policies, ideas and initiatives are not represented.

INTRODUCTION

The Medicaid law (Title XIX of the Social Security Act) was enacted in 1965 largely in the shadow of the more widely recognized Medicare legislation. Medicare, an insurance program, was created to help pay medical bills for most individuals 65 and older regardless of their financial status. Medicaid, on the other hand, is a program financed by Federal, State and local tax dollars to provide quality health care to eligible poor citizens at an affordable price.

For the most part, the Medicaid law provides that those eligible for assistance under one of the categorical welfare programs -- the aged, blind or disabled (now the Supplementary Security Income program) or adults and children in families with dependent children (AFDC) -- are automatically eligible for Medicaid services. In addition, States have the option of providing Medicaid services to the so-called "medically needy" -- that is, those categorically eligible for AFDC or SSI but whose incomes are above the State's need standard for eligibility. Currently, thirty three States provide coverage for the medically needy. States also have the option of covering all children under 21 years of age whose families meet the State's income standard but not categorical requirements. Presently, twenty States have selected this option. Finally, States may elect to cover members of families with unemployed fathers. Thirty one States have chosen this option.

There are nine basic services mandated by the legislation: in-patient hospital care, outpatient hospital care, lab and X-ray services, skilled nursing facility services and home health services for those 21 and older, family planning services, physicians services, rural health clinic services, and early and periodic screening, diagnosis, and treatment for those under 21. In addition, there are many optional services a State may wish to provide for which Federal matching payments are available. Examples of optional services would be drugs, eyeglasses and clinic services. With respect to both mandated and optional services, States have the authority to define the "amount, duration and scope" of these benefits. For example, while inpatient hospital benefits are mandated under the program, the State has the discretion to allow an unlimited number of days of care per year or per illness, or restrict the number of allowable days per year or per illness. Another example would be that a State could legitimately restrict the number of visits to a physician to one per month, if desired. Moreover, in order to help finance the program, States may require recipients to share in the costs of the

optional services. (States can impose cost sharing on the medically needy for both mandatory and optional services, and on the categorically eligible for optional services only.)

The Federal matching payments are based on a complex formula which is designed to provide a higher percentage of Federal matching to States with low per capita incomes. The minimum Federal share is set by statute at 50 percent, with a maximum at 83 percent. (Presently no State receives a match higher than 78 percent.)

A common misconception about the Medicaid program is that it covers all of the poor. It clearly does not. The categorical requirement plus the States' various income standards for eligibility disqualify many low income individuals from participation in the program. Estimates indicate that almost ten million individuals, or forty percent of the nation's poverty population are not eligible for Medicaid benefits. In some States, less than one third of the poverty population receive Medicaid services.

The annual income limits for eligibility vary considerably among States and, in most instances, fall below the national poverty level. For example, the annual income need standard (as of October 1, 1976) for a family of four ranges from a low of \$2,244 in Texas to a high of \$6,168 in Hawaii. The income levels for qualification under the "medically needy" program (as of January 1, 1978) range from a low of \$1,400 for a family of four in North Carolina to a high of \$5,600 in Wisconsin. Moreover, the distribution of Medicaid payments does not correspond with the geographical distribution of the poor. The South receives less than 25 percent of Federal Medicaid outlays but accounts for over 45 percent of the nation's poor.

Medicaid has been criticized throughout the years for its inequities and variations. These criticisms have tended to overshadow the fact that the program has been remarkably successful in meeting its primary objective: namely to improve the overall access of the poor to health care services. Today, the poor who qualify for Medicaid are visiting physicians at a rate equivalent to that experienced by the non-poor. Critics will argue, however, that the quality of care delivered to the poor is different, in many instances, than that received by the non-poor. Nevertheless, it cannot be ignored that low income individuals are utilizing the medical care system at rates which are significantly higher than when the program began.

COST ESCALATION

Since the initiation of the Medicaid program, the growth in expenditures has been quite dramatic. In FY 1966, Medicaid's first year of operation, expenditures totaled \$1.6 billion; in FY 1978 expenditures reached \$19 billion. Projections for FY 1979 estimate expenditures around \$21 billion, representing more than a thirteenfold increase in as many years. On the average the States and local governments account for about 45 percent of the total expenditures. Since FY 74 Medicaid costs have grown over \$2 billion per year -- a 15 percent annual increase. In FY 68 the average annual payment per Medicaid recipient was \$300, while in FY 78 the amount was \$850. The number of Medicaid recipients also has risen significantly over the past several years -- from 9 million in FY 67 (when many States had not yet submitted their program plans) to a projected 22 million in FY 78. However, the growth in recipients has been essentially stabilized since 1974.

One statistic, however, which has remained fairly constant throughout the history of the program is that the largest proportion of expenditures is devoted to institutional services (hospitals, skilled nursing homes, and intermediate care facilities). In FY67 such services consumed 74 percent of program expenditures, while they account for 71 percent in FY 77.

It is also interesting to note that while the aged comprise only 17 percent of the total Medicaid population, they consume almost 40 percent of the total expenditures. Children under 21, however, make up almost 50 percent of the Medicaid population but account for only 19 percent of the expenditures.

The unacceptable rate of increase in State Medicaid budgets over the past several years means that fewer and fewer State dollars are available for many other worthwhile State programs. While some factors contributing to the rapid expansion in the costs of providing Medicaid services are easily discernible -- inflation in medical prices and fees, a greater number of individuals served, growth in utilization per eligible person -- effective and equitable methods for controlling the acceleration of costs are more elusive.

With growing budgetary restraints on the one hand, and rising medical costs on the other, the States' most common approach to the problem was to focus on reducing the scope of services offered, or the number of individuals served under the Medicaid program. However, in recent years the trend appears to move away from cuts in benefits and eligibility as cost saving devices. In 1975, over half the States took some action at limiting benefits through such measures as reducing optional services, limiting inpatient hospitalization or restricting the number of visits to a physician.

During 1977, however, only fourteen States adopted one form of action or another to limit program coverage. Interestingly, in the same year, nineteen States took some action to expand coverage. For example, Delaware, Indiana, and New Jersey added intermediate care facility services for the mentally retarded, Michigan expanded its program to include outpatient psychiatric services, Kansas increased the number of home health aide visits from 100 to 200 per year, and Louisiana added a medically needy program.

Legislators seem to be increasingly aware that benefit and coverage limitations, while yielding short term savings, too often only force a substitution of more costly services, and thereby lead to overall increases in expenditures and sometimes undesirable effects on recipients' health and welfare. Consequently, while benefit limitation represented the most widely used option for controlling costs in the early to mid-70's, it has recently been replaced with more serious attention to structural reforms and management improvements. (However, income standards for eligibility have not kept pace with inflation; this is, in effect, a cut back.)

Increasing recognition has been given over the past few years to the contribution poor management and administration make to overall Medicaid cost increases. The Government Accounting Office and the Inspector General of HEW have suggested that between \$750 million and \$1.5 billion in Medicaid expenditures are wasted or inappropriately spent each year due to fraud and abuse. Examples of Medicaid fraud and abuse include such practices as: billing for services not provided, bill padding by physicians, double billing on claims already paid, kickbacks by clinical laboratories, prescribing excessive services, and overutilization or inappropriate utilization of services.

As early as 1970, New Jersey developed a computerized information system to detect patterns of fraud and abuse among Medicaid providers and recipients. The elements of that system were adopted a few years later by the Department of HEW in developing the Federal Medicaid Management Information System (MMIS). The MMIS is designed to improve claims processing and to check such costly problems as excessive and inappropriate utilization of Medicaid services. Under amendments to the Social Security Act of 1972, Congress authorized 90 percent matching payments to the States for the development of MMIS and 75 percent matching for the costs of operating the systems. MMIS systems are capable of providing a broad range of information including: identification and verification of all eligible recipients and all providers qualified to render services; assurance that correct payments are made to providers; a statistical profile of health care delivery and utilization patterns; and identification of possible instances of fraudulent and abusive practices. As of

March, 1979, twenty three States had fully certified MMIS systems, with the expectation that by end of FY 1979 over thirty States would be certified.

Some States have clearly been more aggressive than others in attacking Medicaid fraud. New Jersey and New York were early pioneers in the field of investigating and prosecuting nursing home operators. Three years ago, Wisconsin established a 30 member strike force against Medicaid fraud and investigation. Audits carried out by the Illinois Bureau of Special Investigation and the Governor's Task Force on Medicaid Fraud resulted in the suspension of 60 providers in 1976.

Recently, the 95th Congress authorized 90 percent Federal matching to States for the establishment and operation of State Medicaid fraud control units. The same law strengthened criminal penalties to be imposed on providers convicted of fraud, as well as the authority to suspend such providers from further participation in the program. Prior to the enactment of the Federal legislation, seventeen States had statutes which authorized criminal sanctions on Medicaid providers and vendors for a wide range of fraudulent and abusive practices. Eleven States adopted statutes which permit suspending a Medicaid provider from participation in the program for administrative, civil or criminal malfeasance.

In addition to fraud control, many States have developed programs to check unnecessary hospital and nursing home admissions and unwarranted lengths of stay in institutions. About fifteen States have systems in effect which require prior authorization for hospital services and extensions of stay for non-emergency hospitalization.

One promising innovation, demonstrating significant cost savings and at the same time protecting the dignity and rights of the elderly and disabled, is the Virginia nursing home preadmission screening program. The program is designed to control the increase in patient admissions from the community directly into long term care facilities. A 1976 pilot project revealed that slightly more than one quarter of the applicants screened could be provided for in the community through various alternative methods of care. Due to the success of the pilot project the State of Virginia incorporated the preadmission screening program into its Medicaid plan. Now preadmission screening is mandated Statewide and Medicaid payments cannot be made without local screening committees' approval.

While the Medicaid statute and regulations require States to ensure that medical services are being utilized at an appropriate level, several States have gone beyond the minimal Federal requirements. The Indiana legislature, for example, established a

joint legislative committee on Medicaid costs utilization. The purpose of the committee, as defined by the statute, is to "compare the scope, utilization, rates, utilization control methods, and unit prices of Indiana's major Medicaid services with other States' Medicaid services, to identify any frivolous utilization and any unjustified provider profits." Moreover, the committee is to "assess the cost effectiveness and health implications of alternate approaches to reduce unwarranted profits and unnecessary utilization."

The States of Minnesota and Missouri, among others, are presently experimenting with a recipient "lock-in" system to cut down on recipient generated misutilization and overutilization. Misutilization is generally discovered through recipient profiles on computerized information systems. Following certain corrective action procedures, such as caseworker contact to explain that services have been overutilized and how such behavior may be dangerous to their health, the caseworker will explain proper utilization and ask the recipient to select one physician and one pharmacy from which to receive their services and medication needs. The individual's Medicaid card indicates that services rendered (except emergency service) by other than the authorized vendor will not be authorized for reimbursement.

States are beginning to focus on cost containment options which encourage more appropriate utilization of services by restructuring incentives in health financing and delivery, to promote more rational priorities for health care.

One of the most promising ways to reduce the incentives and overall demand for the provision of high cost health services is through one of the various forms of prepaid medical practices. The Health Maintenance Organization is perhaps the most recognized example; however, many other prepaid systems exist such as Individual Practice Associations and health care alliances. While only 13 states to date have certified HMOs as a provider of Medicaid services, many more are expected to follow in the near future.

One of the most perverse incentives within the health care financing structure is the provision in Medicaid statute and regulations requiring States to follow the reasonable cost related principles of Medicare in reimbursing hospitals, unless the Secretary of HEW approves an alternative reimbursement method. The reasonable cost reimbursement method has been widely criticized as inflationary, since it contains few, if any, incentives for efficient performance on the part of the hospitals. Instead the reimbursement system tends to stimulate unnecessary and inefficient operations. Consequently, eight States at present have received HEW approval to implement reimbursement methods different from that

which Medicare follows: New York, Massachusetts, Colorado, Michigan, Rhode Island, Wisconsin, Washington and Maryland. Several other States are seriously considering altering their reimbursement methodologies as well. Moreover, some States, e.g. New York, Massachusetts, Connecticut, Maryland, Colorado and Washington, through mandatory rate setting programs, have sought to regulate Medicaid and non-Medicaid rates. The most recent action was taken in the 1978 New Jersey legislative session where the legislature created a Hospital Rate Setting Commission with the power to approve rates for all payers of hospital services. Several other States have adopted or endorsed voluntary rate review program. Significantly, the average annual rate of increase in hospital costs in those States with mandatory programs was 12 percent during 1977, compared to a 15.8 percent average in those States that had no cost containment program.

Other examples of actions taken by State legislatures to reduce health care cost inflation would include recent efforts in Alabama and North Carolina. In 1976, the Alabama legislature appointed a joint Senate-House Committee to examine Medicaid and the increasing financial crisis it presented to the State. At that time Alabama's Medicaid program expenditures had grown to such a point that the State's cost exceeded 25 percent of the entire general fund of the State. It was apparent that the State's investment in Medicaid constricted funds available for such other important services as mental health and prisons. It therefore became necessary for the State to stop and evaluate its Medicaid investment, to examine the program relative to other State priorities, and to devise alternative action.

Similarly, the 1978 North Carolina legislature created a Legislative Commission on Medical Cost Containment. The Commission's chief duty is to review the North Carolina Medicaid program and to lay out a series of options for medical cost containment proposals that will benefit all citizens of the State.

State legislators are also beginning to influence the flow of health care dollars through limitations on the supply of expensive acute care services. Currently, thirty-three States have certificate of need statutes which provide for a public review and check on the unwarranted initiation of expansion in capital expenditures for health care facilities or services.

CONGRESSIONAL INITIATIVES

During the 95th Congress, the Administration introduced several initiatives aimed at improving Medicaid coverage and services as well as containing health care costs.

The Rural Health Care Act, (PL 95-210) enacted in 1977, mandates rural health clinic services under Medicaid and provides for coverage of physician assistants and nurse practitioners under Medicaid and Medicare in rural medically underserved areas. Also adopted in 1977 was the Medicare and Medicaid Anti-Fraud and Abuse legislation which authorized Federal matching payments to the States for the development of fraud control units.

The Administration came close to passing a Child Health Assessment Program (CHAP) which would have expanded Medicaid eligibility to all children under 21 with no categorical requirements at the same time increasing the Federal match for services to these children. Moreover, the proposal would have extended eligibility to all low income pregnant women, plus allowed the States the option of extending eligibility to foster care children with special needs that are placed for adoption. A new version is planned for the current session of congress.

The Senate Finance Committee reported out S1470 -- Medicare and Medicaid Administrative and Reimbursement Reforms. S1470 -- otherwise known as the Talmadge bill -- would have created a new methodology for reimbursing hospitals for routine operating costs under Medicare and Medicaid. The new methodology would have been based on a system of incentive reimbursement -- rewarding hospitals in similar groupings (i.e. according to bed size and patient load) with comparable routine operating costs less than the average and penalizing those hospitals with above average costs. Additionally, the Talmadge bill would have established specific performance standards for Medicaid administration, rewarding those States that exceed the standards, and penalizing those States that fall below the requirements.

The Senate Human Resources Committee reported out a bill, proposed by the Carter Administration, to impose immediate, mandatory controls on all hospital revenue increases. The legislation (S1391) would have restricted such increases to one and one-half times the rate of increase in the GNP deflator. Estimates suggested that the bill if enacted, would have saved between \$50 and \$60 billion to the economy over a five year period. Similar legislative action occurred on both the House and Senate sides.

Fairly late into the 95th Congress, Senator Gaylord Nelson of Wisconsin introduced an amendment intended to serve as a compromise between the immediate, mandatory Federal controls proposed by the Senate Human Resources Committee, and the very limited Medicare/Medicaid, routine operating cost approach sponsored by the Senate Finance Committee. Senator Nelson's amendment would have established in statute goals for a voluntary hospital cost containment effort. Specifically, the voluntary goals stipulated that the rate of increase in hospital expenses be held to 2 percent

less in 1978 and 4 percent less in 1979 - 1982 than the rate by which such expenses increased in 1977. If the hospital industry was unable to meet the voluntary goals on an aggregate basis, mandatory controls applying the new reimbursement methodology of the Talmadge bill, but extending to all costs and all payers, would go into effect. Even if the national voluntary effort failed, however, hospitals would be exempt from controls in any State which met the national goals, or which had in effect a State cost containment program. Moreover, the Nelson amendment would have provided start-up costs to States willing to develop alternative hospital cost containment programs. Projected savings to the economy if the Nelson amendment had been enacted were between \$30 to \$35 billion over a five year period. Significantly, the Nelson approach was adopted as an amendment to the Talmadge bill by the Senate; however, the House failed to consider the measure in the closing days of the 95th Congress.

The Carter Administration has submitted a new hospital cost containment bill (S570) to the 96th Congress.

THE STATE LEGISLATIVE ROLE

The importance of the State legislature as a key participant in an overall cost containment strategy cannot be overemphasized. Legislators, until recently, placed far greater emphasis on their policy formulation responsibility, much to the neglect of their oversight role. However, while States' legislative oversight still remains uneven, there can be no doubt that the legislatures are increasingly aware of the importance of program accountability and control to curbing waste and mismanagement of State funds in programs such as Medicaid. Beyond legislative oversight, some States are realizing dividends through careful assessments of the effectiveness of State policies and programs.

Within the past few years, Congress and HEW have demonstrated through several initiatives their desire to improve the State legislature's ability to exercise a more meaningful oversight responsibility for the Medicaid program. The attractive Federal matching payments for the development and operation of MMIS systems is one example of such assistance. While MMIS is designed to help program managers, it produces information useful to State legislators in their oversight role. Another example is the support HEW has extended to the National Conference of State Legislatures over the past two years for producing several training seminars on Medicaid reform. These seminars served to improve the knowledge of State legislators and staff about the various components of the Medicaid program, as well as provide legislators with an opportunity to advise Federal officials how the overall

program might be improved. Moreover, the Medicaid / Medicare Management Institute, which exists for the purpose of identifying effective State practices and facilitating the exchange of pertinent ideas about improvements in the program, on request makes available current data to appropriate State legislative committees (as well as the State agencies) in order to provide them with a basis to judge how effectively their State's Medicaid program is operating, and how it compares to other State programs. Finally, under an initiative of HEW Secretary Califano, the entire set of Medicaid regulations was recently rewritten for clarity and simplicity, without policy change. This effort to help non-technicians such as elected officials, and program beneficiaries to become more familiar with the Medicaid program requirements could be a positive force in restoring integrity and public support for the program. In time increased understanding of the program elements will lead to even more effective oversight and accountability.

It is hoped that the near future will witness productive negotiations between the States and the Federal government in producing meaningful performance standards for program administration. Performance standards will provide legislatures with even better benchmarks to evaluate how effectively their own State program is operating.

CONCLUSION

Public disclosures of extensive fraud and abuse in the Medicaid program, along with serious fiscal crises in many States, prompted State and Federal officials to search for ways to restore integrity to the program and to reduce escalating costs. Efforts to curb fraudulent practices by providers, to ensure proper utilization of services by eligible recipients and to promote efficient program management are desirable objectives and should be implemented swiftly. However, these actions are not the key to containing health costs, as many of the authors of papers included in this report have indicated.

The problem of inflation in health costs is a system-wide concern; it cannot be limited to Medicaid alone. As one analyst observed, "Medicaid is expensive because medical care is expensive." The problems in the general health care system are deeply entrenched and structural, involving basic incentives that produce the inefficient behavior of the total system. These problems are unlikely to be strongly affected by simple modifications in a program serving only ten percent of the nation's population and accounting for less than eight percent of the nation's health expenditures. However, by failing to see

Medicaid's problems in the context of the total health care system, one runs the risk of devising solutions that may exacerbate present difficulties. The Medicaid program does provide opportunities for effecting structural change through a "purchaser of services" role, rather than functioning as a mere reimbursor.

How the States address, or fail to address, both the problems in their Medicaid systems, and the broad health care issues faced by society, will have a large bearing on the extent and the nature of the States' role under a national health insurance program.

This publication represents another step in encouraging State participation in developing national health policy, by summarizing current experiences with the Medicaid program as a focus for future discussion, analysis and problem solving.

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I. MEDICAID: A STATE-FEDERAL PROGRAM

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A DECADE OF MEDICAID

Creation of Medicaid and Medicare by enactment of the Social Security Amendments of 1965 established a major role for the Federal government in financing health care. Medicare, Title XVIII of the Social Security Act, provides health insurance to persons aged 65 years and over who are eligible for social security. Medicaid, Title XIX, is a Federally assisted State program which offers health benefits to low-income persons on public assistance and, in some States, to those deemed medically needy because their incomes are only slightly above the welfare standards. Depending upon the per capita income of a State's population, the Federal government pays between 50 and 78 percent of the costs of the State's Medicaid program. Within broad Federal guidelines, the States determine the eligibility of recipients, scope of services, and amounts paid to providers.

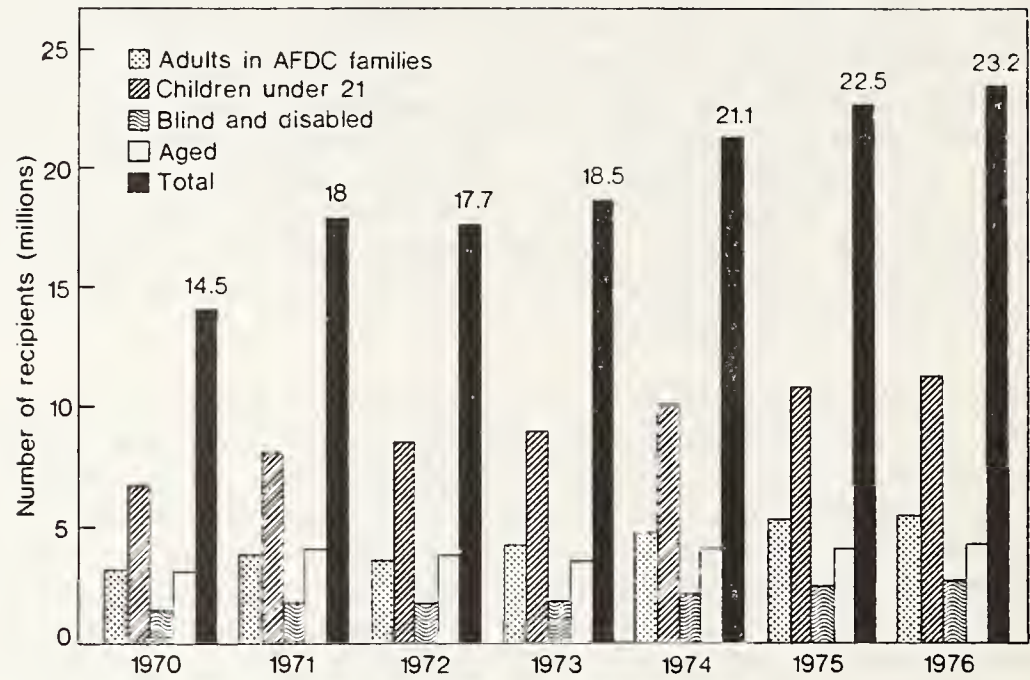
Today, 10 years after its inception, Medicaid is assuring financial access to health care services for more than 23 million persons (Fig. 1). However, dramatically escalating costs, operational weaknesses, and provider and recipient fraud and abuse have placed the program under increased scrutiny. While the likelihood of replacing Medicaid with a comprehensive national health insurance program continues, Congress and the President have put forth proposals for redefining the Federal-State partnership -- their respective roles, responsibilities, and resources -- in financing health services to the poor.

ANTECEDENTS OF MEDICAID

Although the enactment of Medicaid legislation represents the most dramatic commitment, Federal financing of health care for the poor has been part of the State welfare system since the 1930s. Motivated by the depression, the Social Security Act of 1935 marked the beginning of the American social welfare system, which provides government protection from financial calamities for "deserving individuals." From this legislation two concepts of social welfare emerged: social insurance for the working population (unemployment insurance, workmen's compensation, guaranteed pension) and public assistance -- direct financial aid provided by the States -- for those unable to work.

The Social Security Act established categorical assistance programs for needy aged and blind persons, for one-parent families with children, and later for the disabled. Although the act did

Figure 1. Number of Medicaid recipients in the United States, fiscal years 1970-76



not provide medical insurance per se for recipients of categorical assistance, the individual recipient's medical expenses were included in determining the size of the monthly payments, which could be matched by Federal funds. Participation by the States in the Federal categorical programs was, however, optional and, as a result, medical services remained only a small part of welfare assistance.

The Social Security Amendments of 1950 expanded the categories of public assistance and provided for a Federally supported program of direct reimbursement -- vendor payments -- to physicians and hospitals. States were encouraged to take part in the program and, within 10 years, approximately 40 States had plans.

The Kerr-Mills Act of 1960 provided more generous, open-ended Federal matching for all vendor payments and established a new category of public assistance -- "medically needy" aged persons who were not receiving cash assistance. By the end of 1965, 50 States and 4 jurisdictions had Federally approved vendor payment programs for medical care.

MAJOR FEATURES OF MEDICAID

The Kerr-Mills program was viewed by many as only a temporary solution to the problem of providing medical care for the aged. Even before the States had fully implemented Kerr-Mills, organized groups of senior citizens questioned why the elderly should be forced into retirement and required to accept welfare to receive health services. The special needs of the elderly coupled with rapidly increasing hospital costs and the plight of impoverished minorities brought strong pressure on the Congress throughout the early sixties to enact a compulsory health insurance program. A myriad of health proposals were introduced, such as subsidized insurance for the aged for physicians' services, hospital insurance for the aged under social security, and larger Federal grants to the States to provide health care services to indigents. Finally, in July 1965 several of the proposals were combined to form Medicare and Medicaid.

Medicaid was the "sleeper" of the 1965 legislation. Congressional debate had focused almost exclusively on Medicare, the program for the elderly. By contrast, Medicaid, which was viewed as an extension and improvement of the Kerr-Mills program and the existing welfare system, was quickly written and hastily passed. Its architects never delineated clear goals or came to grips with the problems endemic to the structure of the welfare programs, particularly the problem of determining eligibility through means tests. Furthermore, as Medicaid began, policymakers

had no clear sense of the potential costs of the program or of the impact of pumping vast sums of Federal dollars into the private sector of the medical market.

Medicaid's goal, however vague, was ambitious: "to provide the poor with the same access as the rich to mainstream medical care." Each State was encouraged "as far as practicable to provide medical assistance to families with dependent children and to the aged, blind, and permanently and totally disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services." By 1975 the States were to offer "comprehensive care for substantially all individuals." Within a matter of months the term "comprehensive care" became more "symbolic than substantive": A 1966 policy interpretation by the Department of Health, Education, and Welfare (DHEW) required only that the State "show progressive steps in the direction of a comprehensive scope of medical care and services." [1]

The Medicaid program has these major features:

- Like the earlier welfare programs, it is a Federal-State partnership which the Federal government provides financial support and general guidelines, and the States assume control and direction of operations.
- It requires a participating State to cover all persons receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. (Before implementation of the Supplemental Security Income (SSI) program in 1974, States were also required to cover all aged, blind, and disabled cash assistance recipients.)
- It gives a participating State the option of including medically needy persons in the following categories: dependent children and their families, the aged, the blind, and the disabled.
- It substitutes a single program of medical assistance for the payments under the categorical programs for cash assistance for the aged.
- It offers a higher rate of Federal matching for vendor payments than the Kerr-Mills program.
- It requires a participating State to offer under its program the following services: inpatient and outpatient hospital services, rural health clinic services (added under PL 95-210, December 1977), other laboratory and X-ray services, skilled nursing services, physicians' services, home health

services, and EPSDT. The amount, scope, and duration of the basic services are left to the discretion of the States.

- It allows the States to pay for other specified health care services and receive Federal matching funds for these optional services.
- It emphasizes State responsibility rather than the local responsibility stressed in the earlier welfare programs.
- It retains from the previous welfare structure the concept of vendor payments (payments made directly from the State to health care providers) and expands the concept of the medically needy to include all persons, not just the elderly, whose medical bills are beyond their means but who are not eligible for cash assistance.

Although the States are not required to have a Medicaid program, strong incentives have been provided. After December 1969, no Federal funds were available for medical vendor payments for the categorically-related health assistance programs or for Kerr-Mills programs. Also, Federal matching funds were offered to help States pay for the administration of their program. Today, 49 States, the District of Columbia, Guam, the Virgin Islands, and Puerto Rico offer Medicaid. Thirty-two programs cover the medically needy in addition to welfare recipients.

PROBLEMS IN MANAGEMENT

Problems in management of the Medicaid program developed immediately in implementing the sometimes vague and often confusing legislation. Because Medicaid was the outgrowth of earlier programs, implementation proceeded simultaneously at the Federal and State levels. Many States with well-organized Kerr-Mills programs began developing State plans as soon as the bill was passed and thus pre-empted the opportunity for Federal initiative and direction.

Meanwhile, at the Federal level the question of whether Medicaid was an income-maintenance program or a health program created an organizational dilemma. Should the program be administered by HEW's Welfare Administration or Public Health Service? After lengthy discussion, the task of administering Medicaid was given to the Division of Medical Services in the Bureau of Family Services of the Welfare Administration, which had previously been charged with oversight of the Kerr-Mills programs. Twelve new positions were added to the division's staff of 23, including clerical personnel, as it began interpreting the

legislation, preparing guidelines, negotiating with the States and jurisdictions, and administering a budget which within a year totaled \$1.6 billion.

By contrast, Medicare's implementation, according to Robert and Rosemary Stevens' history of Medicaid, "had the advantage of being a completely new program, one administered solely from the Federal level by a well established, well ordered and well accepted entity in HEW." [2] Ample planning time, in which staff were hired and preliminary guidelines prepared, preceded the implementation of that program.

The first congressional attempt to improve the management of Medicaid came with the passage of the Social Security Amendments of 1967. Enacted only 2 years after the bill's passage and only 1 year after most State programs were started, these amendments reflected growing concern by the Federal and State governments with the administration of the program. Federal guidelines were established requiring States to review, on a continuing basis, the costs, administration, and quality of medical care provided in their programs. Stricter standards to insure quality care and periodic reviews to appraise utilization patterns were required for nursing homes.

In attempting to improve administration of the Medicaid program, the 1967 amendments also greatly expanded the Federal responsibility. Concerned with the health of children in low-income families, the Congress mandated, for persons under 21 years eligible for Medicaid, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to "ascertain their physical and mental defects and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered...." Thus, not only is child health now a major program priority, but the States are expected to administer and the Federal government is expected to oversee a program for the direct provision of health care services.

In 1970, a Senate Finance Committee report [3] and an independent DHEW task force (McNerney report) [4] underscored the need for better management of the Medicaid program. The Division of Medical Services, which had been given bureau status and renamed the Medical Services Administration in 1967, was given 80 new positions, bringing its total to 160. Two management themes were stressed: improving management information systems in the States and strengthening procedures for developing policy guidelines and regulations.

The Social Security Amendments of 1972 reflected the continued disenchantment of the Congress with the program. In an effort to improve State compliance, penalty provisions were enacted which

allowed Federal funds to be withheld from States for failure to implement the utilization review and EPSDT programs mandated by the Congress. In addition, the amendments established professional standards review organizations composed of practicing physicians in local areas to undertake a comprehensive and ongoing review of services under Medicaid and Medicare to determine if they are "medically necessary" and in accordance with professional standards.

A major shift in the Federal posture has occurred in the last few years. As the Medicaid program has matured, the Federal focus has shifted from encouraging expansion of State programs to assuring their integrity. The Federal government has developed a number of measures designed to assure that appropriate and high quality care is delivered only to eligible recipients by qualified providers and is currently undertaking in-depth review of several aspects of the programs.

Medicaid's eligibility quality control program is designed to insure that all Medicaid recipients are actually eligible for the benefits. This activity complements the AFDC eligibility quality control program and the Social Security Administration quality assurance program covering Medicaid recipients whose eligibility is determined by the Social Security Administration.

Provider fraud and abuse is being attacked through evaluation and monitoring of the States' fraud and abuse surveillance activities. The Federal program is designed to document and highlight a State's capability to identify and prosecute providers who are benefiting unfairly from treating Medicaid patients. Once a State shows that it can detect and take action on fraudulent or abusive practices, the incidence of these practices rapidly declines.

Financial reviews are Federal studies which evaluate the effectiveness of State operations and the appropriateness of Federal reimbursement for State claimed expenses for these operations. As many as 12 different reviews can be made in each State to identify weaknesses, provide technical assistance, and save Federal funds.

HIGH COSTS

It was apparent almost from the start that costs of the Medicaid program would exceed projections. Budgeters with little reliable actuarial data on which to base their estimates had anticipated that Medicaid would add \$250 million to the \$1.3 billion in vendor payments for Kerr-Mills programs in 1965. By

1967 program costs had already passed \$2 billion and were rising steadily. (All figures are for fiscal years.)

The Social Security Amendments of 1967 instituted a limited definition of "medically needy" in an effort to control program costs. By 1969, however, the payments to providers of health services had increased to \$4.4 billion (Fig. 2), and Congress stated that the goal of having a "comprehensive" Medicaid program in all States could be postponed until July 1, 1977, and that the States could drop optional services if they faced serious budget constraints.

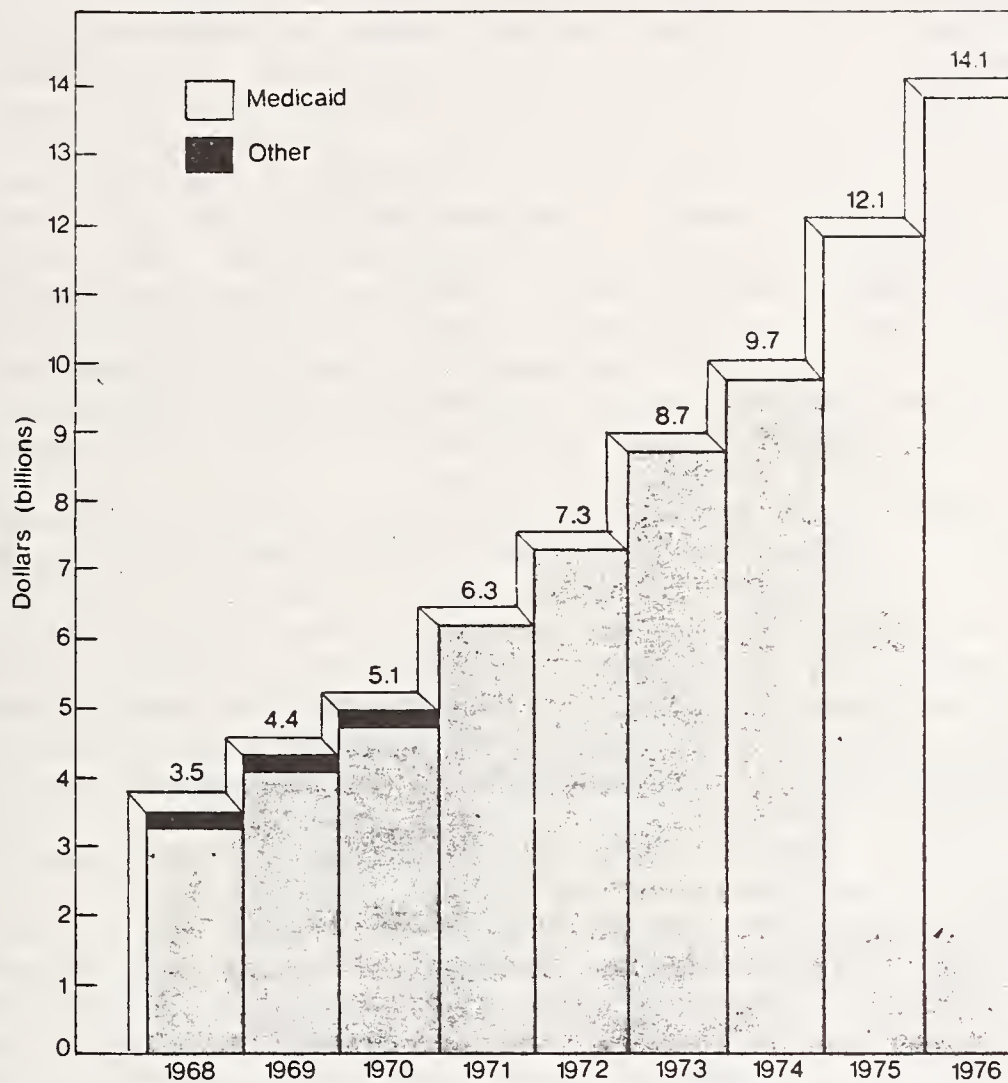
The 1972 amendments to the Social Security Act, passed after program costs had increased 91 percent between 1969 and 1972, from \$4.4 billion to \$7.3 billion, made significant changes in the program. The requirement that States move to "comprehensive care" was eliminated. States were permitted to control costs by requiring cost sharing for the medically needy and for optional services used by categorical recipients. A brief glimpse at the national and State Medicaid budgets make it readily apparent why some cost containment strategy is essential. Program costs rose from \$4.5 billion in FY 70 to \$17.5 billion in FY 77. Projections for FY 78 estimate over \$19 billion in expenditures. A comparison of the rise in total expenditures for Medicaid and Medicare between 1976 and 1977 offers perhaps the most compelling reason for cost containment. In a single year the increase alone in these two programs exceeded \$7 billion! To place the \$7 billion figure in perspective, it is greater than the total Federal investment in all other health programs combined.

In the past few years, however, increasing Medicaid costs have not been the result of dramatic increases in recipients, but rather have been more a function of inflation in health prices. The data does indicate that since 1975, the U.S. has experienced a decreasing rate of expenditures in the Medicaid program. The trends at least are in the right direction: from a 24 percent increase in 1975 to 16 percent in 1976 to 14 percent in 1977 and an estimated 12 percent in 1978. These reductions in the rate of increase are partly because some of the cost containment efforts such as quality control, fraud and abuse, surveillance and utilization review are beginning to register an impact.

BASIC DIFFICULTIES

In spite of all the amendments, inadequate program management and high costs have persisted. The reasons are undoubtedly many and interrelated, but perhaps the major shortcoming of the amendments is their failure to attack basic problems. Efforts to

Figure 2. Medicaid and related program payments to providers of health care, fiscal years 1968-76



¹ Payments to intermediate care facilities are included in the totals for fiscal years 1969-72 even though they were administered under the cash assistance program until Jan. 1, 1972, when they were transferred to title XIX.

improve program management never attempted to deal with the basic difficulty of implementing complicated legislation, particularly that concerning eligibility. Eligibility criteria are so complex that, for example, 500 caseworkers are needed to determine eligibility for patients in the Los Angeles County hospital alone, a fact discovered in a 1975 review of California's program by the Medical Services Administration.

Nor have the amendments eliminated the confusion over where accountability and program control rest in the Federal-State partnership. As Federal expenditures for Medicaid have risen, so has the Federal concern over how well the money is being spent.

From an initial posture of monitoring and advising, the Federal role has grown to include the function of oversight. Target areas for oversight have been identified: long term care, management information systems, fraud and abuse, and control of utilization. Yet despite the increased expectations for Federal oversight of the 53 programs, the Federal "presence," or capability, has remained small. Thus the amendments added increased responsibility without adding commensurate resources and control.

Similarly, efforts to control program costs have focused on eliminating services, instituting cost sharing, and reducing unnecessary utilization without ever tackling the inflationary aspects of the legislation -- the provisions for "reasonable cost reimbursement" to providers and open-ended Federal matching. Furthermore, there has been little recognition that Medicare's incomplete coverage for long term care would require Medicaid to devote approximately 40 percent of its funds to long term care.

One other problem for which Medicaid has been harshly and justifiably criticized, but which has received little attention from the Congress, is its inequity among the States, a criticism particularly valid since the program is more than 55 percent Federally funded. As a result of variations in eligibility requirements, persons who would receive benefits in one State may not be eligible in another State. Thus, Medicaid does not cover all the poor, by any means. In 17 States for example, fewer than one-third of the poor received medical benefits from Medicaid in 1970.

FEDERAL-STATE RELATIONS IN MEDICAID

The success of the Medicaid program is dependent on close cooperation between the executive branches of government at the Federal and State levels. But it is extremely difficult for the program to operate successfully at the State level unless there is

an active oversight capacity on the part of the legislative branch. Unfortunately, not enough attention has been devoted to oversight. The nation needs more informed legislators at both the State and Federal levels of government, and better qualified administrators in the executive branches, if the myriad of problems of Medicaid are ever to be resolved.

Another way in which State legislators can help restore some integrity to the Medicaid program is by insuring that its own Medicaid statute and regulations are easily understandable by all the members of the legislature, by those who have to provide services under the program, and by actual and potential recipients of the program's benefits. The legislature should make it possible for the program to be administered and implemented with adequate controls. If one examines the history of the Medicaid program, it is clear that too little thought was given initially to how to control and manage the program. The view held in Washington during the early years of the program apparently was: "Since the program is obviously a good one, the more money spent on it, the better." The effort was part of the Great Society programs of the 60's and therefore the concern was with getting money out to recipients. Not enough questions were asked, however, as to whether the money was actually going to those in need of care and what was happening to those dollars as they flowed out into the system.

The Federal government has a responsibility-which to this point it has not exercised very well-to provide the States with an overall assessment of how well their programs are being managed. The Department of HEW is, however, at the present time building an assessment program which can begin to provide some useful feedback to State administrators and legislators on how effectively their Medicaid program is operating.

Technical assistance is a critical function for the Federal government, but technical assistance unfortunately has too often been only a "buzz" word used by bureaucrats. The truth is that many States have done an excellent job with respect to many of the operating components of their Medicaid program, and what is needed is to find effective ways to transfer that technology, skill, and knowledge from one State to another. The establishment of the Institute for Medicaid Management within HEW in 1977 (now the Medicaid/Medicare Management Institute, with the 1979 reorganization of HCFA) was designed to meet those objectives. Over the past year, the Institute has conducted a number of training programs on such important topics as third party payment recovery and fraud and abuse control, where the principal faculty came from States that have demonstrated leadership and skills in operating those elements of their Medicaid program. The efforts of the Institute will undoubtedly receive growing support and emphasis by the Department in the years ahead.

What other Medicaid related issues must State legislators be concerned with aside from cost containment? Program integrity or fraud and abuse control is undoubtedly a critical issue. Clearly, the whole management of the program is another area that needs greater attention than it has received in the past. State legislators, as the responsible agents for program oversight, must assure themselves that they have good, tough administrators and that administrators have the resources to effectively manage the program. Unfortunately, there has been a tendency within some States and within the Federal government to be very stingy on the administrative side, while leaving the "flood gates" wide open on the program side. So improved Medicaid management ought to be an essential component of a State's cost containment strategy.

The management and operation of Medicaid programs is very big business. To effectively manage the system, administrators must be able to draw upon sophisticated management techniques and resources. It is the State legislature that can provide those resources, and once having done so, it is the legislature that must hold the administrators accountable for their performance.

It is revealing to note that nationally only 4.5 percent of total Medicaid costs is devoted to the administration of the program, whereas Blue Cross-Blue Shield spends 7.5 to 8.5 percent and the commercial insurance companies somewhere between 10 and 15 percent. Legislators must begin to question whether their State is providing adequate resources to effectively administer and control their Medicaid program. While it is difficult to prove a direct correlation, many would argue that there is a qualitative difference in those State Medicaid programs which contribute 2 to 5 percent to administrative operations as opposed to those which operate at a level of 7-8 percent.

ACCOMPLISHMENTS

During its 10 years, the Medicaid program has produced two major accomplishments: It has improved dramatically the financial access of the poor to medical services, and it has provided experience that is proving valuable in considerations of national health insurance.

Access to Health Care: Without question, Medicaid has extended health care to low-income persons who otherwise would not have received services. According to HEW's recent report on health trends in the United States [5], in 1964 approximately 28 percent of the poor had not seen a physician in the previous 2 years; by 1974 that figure had dropped to 17 percent.

It is estimated that one in every five Americans has received some medical care through the Medicaid program. In 1974 alone, more than 21 million persons received at least one service reimbursed under the Medicaid program.

Currently, the poor are using health services at about the same rate as the nonpoor. In fiscal year 1973 the average health care bill was \$384 for all Americans, compared with \$432 for Medicaid welfare recipients and \$749 for the medically needy and institutionalized Medicaid recipients [6].

Lessons for National Health Insurance: As the largest and most direct Federal program for provision of health care services to a broad range of recipients, Medicaid has provided experience that may prove valuable in considering the effects of a national health insurance program. It has afforded States the opportunity to influence and shape their health delivery systems -- to test various administrative mechanisms and to deal with such items as size and structure of benefits, cost sharing, alternative approaches to long term care, rate regulations, and health maintenance organizations. The mushrooming cost of the Medicaid program, due primarily to the large increase in recipients and inflation in health care costs, has caused concern and caution among policy-makers about enacting a comprehensive national health insurance program.

Experience with Medicaid shows clearly that a successful national health insurance program is possible only if the operational problems of a large public program for financing health services are solved first. Solution of these problems requires high-level commitment in the legislative and executive branches of both Federal and State governments. It also requires managers who are not only strong and tough but also compassionate and sensitive. Any legislation aiming toward national health insurance must address public policy issues such as equity of benefits, as well as existing operational problems.

CONCLUSIONS

Recent events, including Medicaid cutbacks in many States and documentation by the General Accounting Office, the media, Congressional committees, and HEW of extensive operational weaknesses in the Medicaid program have produced a consensus that the obstacles to an equitable and comprehensive health care program for the poor must be eliminated. Either the Federal presence -- staff, accountability, and authority -- must be increased multifold to allow effective and efficient management of the 53 separate

State Medicaid programs, or the States should be made clearly accountable for providing health care to the poor.

Over the next few years, the Congress and the President will determine how health care for the nation's poor shall be financed and administered. The basic administrative issue is whether the Federal government or the State governments will have primary responsibility for the system. The experience with the first decade of Medicare and Medicaid will influence the decision on this issue and will provide the knowledge needed for a successful implementation of the decision.

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MEDICAID AND COST-EFFECTIVENESS

State legislatures hold the key to containing health care costs, particularly with respect to my special area of concern -- the Medicaid program.

As a former executive director of a State department of health and social services, I can speak from first-hand experience of the difficult choices State officials are being asked to make between competing social and economic priorities. It is my sincere hope that legislators will come away from this conference with a better understanding of what I believe are some very real opportunities to contain health care costs within your own State, and thereby have more money to spend on other priorities.

I am sure that it will come as no surprise to you to learn that:

- The nation's total annual spending for all health care costs has more than quadrupled over the last 10 years -- from \$39 billion to over \$165 billion; or that
- National expenditures for health are taking an increasingly larger bite out of the GNP (5.8% of the GNP in 1966; 8.8% of the GNP in 1977); or that
- Based on present trends, the country will spend nearly \$310 billion -- or about a third of a trillion dollars -- on health care by 1983.

All of these huge sums remind me of a remark the late Senator Everett Dirksen made when someone else was rattling off such seemingly astronomical dollar figures. Dirksen stopped him in mid-testimony and said in those beautiful golden-throated tones of his:

"A million dollars here, a million dollars there, and pretty soon, we are talking about real money."

Let's talk this morning about the real money you are spending on health care, and what, together, we can do about it.

QUALITY OF CARE

What are we -- and I mean you, the States, as well as the Federal government -- getting for all this money?

In point of fact:

- Are not the bulk of our expenditures for the treatment of the ill, rather than for the care of the healthy?
- Should we not be establishing in some quantifiable manner what effect the medical procedures and treatment regimens for which we are paying are having on the morbidity and mortality of our population?
- In truth, do we even know what constitutes quality of care?

Assuming that we could get a better handle on this difficult question of quality -- a big assumption, I admit -- it would be time consuming and costly to develop such data. And for better or worse, we Americans are not known for our patience.

The result is that it is the process not the outcome that we generally measure. We don't think we can measure output so we end up measuring input -- number of hospital visits, hours worked, patients seen in a given year.

But, even under these less than ideal terms, a second problem exists: defining who the consumer is. Is the consumer the patient? The patient and his family? Can the government as the payor of health care be considered a consumer in any sense?

Dr. Lang Burwell has said:

"In pre-depression days, the issues of quality and cost control were largely the concern of the physician and his patient. The physician provided the best care he knew how to give within the limits of what the patient could afford. The patient, on the other hand, was restricted by what he could afford to choosing a doctor, and did the best he could to choose among the limited resources available to him."

I ask you: With health care costs escalating so rapidly, is it a degradation of quality for the government to pay for the "best care within the limits of what it can afford" as determined by elected government representatives and policy makers?

ADMINISTRATION COST CONTAINMENT EFFORTS

What efforts are being made to control costs without sacrificing quality? I would like to start by reviewing some of the Administration's recent efforts to contain rising health-care costs.

In my opinion, there are few other areas of our national economy where there is as great a need for anti-inflationary measures as in the health care industry. Passage of the ideas contained in the Administration's hospital cost containment act is of paramount importance. I believe the hospital cost containment act represents one of the best opportunities we have to curtail rising hospital costs on a national level. As you know, it was introduced more than a year ago, and it is still awaiting final congressional action. Fully 40 percent of health care costs today are hospital costs. The inflation rate in hospital costs last year alone was 15.3 percent. And the Consumer Price Index has indicated no let up in hospital price increases in recent months. Today the need for hospital cost containment is more critical than ever.

The proposed cost containment legislation is geared to allow for a wide variety of adjustments and exceptions. Nonetheless, we still believe the program is basically simple to administer and will require no new audits or monitoring programs. Because of the interest which the bill has raised on the Hill, the Administration is currently evaluating a number of proposed amendments to it. One very important concern is enabling the States to have a strong voice in the control of hospital costs.

As a former chairman of a large hospital's finance committee, I remain very much in touch with the effects which Federal proposals are having on hospital costs. Even the threat of a lid on escalating costs is beginning to have a beneficial effect on the industry.

Friends over at the American Hospital Association are proud to point to a number of voluntary efforts which State hospital associations have undertaken to control costs. Michigan, Missouri, North Dakota, Ohio, Texas, Pennsylvania and New Jersey are but a few of the States they tell me are having some real success with the problem on a voluntary basis.

In Pennsylvania, for example, a Statewide target for reducing the rate of increase in hospital expenditures has been identified. Operating budgets are being reviewed to determine ahead of time whether or not it is likely that the hospital will remain within the self-imposed ceiling. And if it looks like the hospital isn't going to make it, the State association provides technical

assistance to help the hospital meet its goal.

In New Jersey, a voluntary State committee consisting of a broad spectrum of business and professional leaders is attempting to hold down costs by pulling together material to help hospitals with their discharge planning, shared services, hospital employee productivity and energy conservation, to name just a few areas.

Now, I am in no position to judge the final success or failure of these voluntary efforts. But I do know that much of this activity was only recently gotten underway--at about the same time President Carter sent his hospital cost containment proposals up to the Hill.

SPECIFIC HEW STEPS

With regard to some specific activities being undertaken by HEW, Secretary Califano announced several months ago a number of initiatives that HEW would take -- and States could take -- to control the precipitous, and corrosive, rise in health care costs. These include:

- Development of regulations to limit Medicare payments for laboratory tests and for medical equipment to the lowest price that is widely available for the same quality in a particular community, instead of paying on the basis of average charges or even higher ones.
- Introduction into Medicare of new and tighter computer screening techniques like those used by the IRS, to flag health care services that should be audited to determine if they are medically necessary.
- Work with PSROs, to set specific goals for lengths of stays, and use of tests in order to reduce excessive hospitalization and unnecessary procedures. In my opinion, the most telling effect of PSROs may be in terms of increased quality rather than substantial dollar savings.
- Acceleration of our plans to implement our "second opinion" program which is designed to reduce the amount of unnecessary surgery performed in this country.
- And, revision of current Medicare regulations to encourage non-profit hospitals to pool their resources and to share services, from laundry and billing services to basic medical programs.

In addition, the Secretary has also written to the governors of each of the States and territories to request that they work together with their respective legislatures to:

- Take all necessary action to promote the substitution of generic prescription drugs for more expensive brand name drugs, both in the Medicaid program and more generally. The Food and Drug Administration will provide technical assistance in this area to any State that desires it.
- Stimulate the development of Health Maintenance Organizations and encourage enrollment in HMOs by State employees and Medicaid beneficiaries, and
- Support health planning activities designed to curb construction of unneeded health care facilities that lead to surplus hospital beds and equipment.

MEDICAID AND COST CONTAINMENT

Now let me turn to a subject which is particularly close to my heart: the Medicaid program.

Medicaid today covers nearly 23 million Americans. It involves half of the 17,000 convalescent facilities in the country, as well as half of the 7,000 hospitals. Seventy percent of all pharmacies, and 40% of the 250,000 practicing physicians also participate in our program.

In terms of dollars, Medicaid is bigger than either General Motors or ITT. This year we will spend \$18 billion, and next year we will spend close to \$20 billion. Twenty billion dollars - that works out to \$60 million a day that will be paid out through the program. Now that's real money even in Senator Dirksen's terms.

What have we gotten in return for all this money? Three major achievements for which the program is at least partially responsible include:

- Reduction of infant mortality rates among the poor from 75 per 1,000 to 35 over the last 10 years.
- A 40% increase in the number of physician visits by the medically indigent from 2 1/2 visits per year several years ago to nearly 4 per year today, and
- An overall feeling in the country that things are getting better not worse, and that States themselves are playing an important role in the determination of benefits for the

Medicaid system.

While it would be presumptuous for the Medicaid program to take all the credit, I do believe we are having a very beneficial effect on the health care status of this country.

MEDICAID QUALITY CONTROL PROGRAM

In Fiscal 1978, we will spend approximately \$20 billion to purchase care for more than 23 million people. Of this amount, States will contribute over \$8 billion. Because of the vast amount of money involved, we have undertaken a broad array of initiatives to reduce costs and increase efficiency.

There are four specific steps HEW is taking which I believe can help State officials get a better handle on their own State health care program costs.

The Medicaid quality control program is our primary effort to detect errors within our system. Initially, it was a major part of the AFDC cash assistance program in the early 1970's.

Medicaid has expanded the QC program to detect errors in beneficiary eligibility for all of our State programs. Interestingly enough, even the threat of penalties in the AFDC program - from errors detected with QC - had a significant impact on reducing our error rates.

We are very pleased with the results of this program. And we are beginning to expand it. One particularly fruitful area that we are anxious to have MQC expand into is the virgin territory of third party liability. As you may know, Medicaid is supposed to be the payor of last resort. What that means is that if our beneficiary has Workmen's Compensation, Blue Shield/Blue Cross, Medicare or any other sort of coverage, those payors should pay first. Only after all other sources have been tapped are the State and Federal funds in the Medicaid program supposed to be called upon.

Unfortunately, we have found that this has not always been the case. The Medicaid Quality Control program is helping us to detect these errors and beginning to save us both considerable amount of money.

I strongly urge that if you want to find out more about MQC, what it is and how it can help the taxpayers of your State, you should contact your own State director of Medicaid. And if he or she can't answer all of your questions give us a call in

Washington. We're here to help you.

MEDICAID MANAGEMENT INFORMATION SYSTEM

A second initiative we have undertaken to control costs is the Medicaid Management Information System. MMIS helps us improve our control over claims processing errors. But it is much more than that: MMIS provides a broad data base for statistical analysis of past trends, present circumstances and future possibilities.

As one of the first directors with a certified MMIS program I can testify to its usefulness. Even Congress is beginning to see its usefulness. Originally authorized to match States on a 50-50 basis, Congress has recently authorized a considerable higher match of 90-10 for development costs of a State's MMIS and 75-25 for operating costs once a program is up and running.

The States are taking us up on our offer. When I came on board last April, 15 States had a certified MMIS program. Today 19 are currently certified and 3 more are in the final stages. By the close of this year we plan on having 25 systems up and running.

STATE ASSESSMENTS

A third very productive initiative we are undertaking with the help of the Regions, is State assessments. The real goal of this program is assistance to the States.

Prior to going into a State, our team carefully review existing material and gathers as much information as we can about how well the State's Medicaid program is doing. We may send eight to fifteen people into a State for an intense two week period. That's a lot of people encumbering a lot of other people's time. But we try to schedule the reviews rationally. And we are working to coordinate our efforts with other review activities such as fraud and abuse to make the best use of everyone's time.

The end product of this effort is appreciable. A report is compiled which gives State legislators and the public a snapshot picture of their own State system - what it's doing right, who it serves and what some possible opportunities may be to improve the situation even more.

CORRECTIVE ACTION PROJECT

A fourth and final initiative I would like to share with you is CAP - the Corrective Action Project. CAP is our effort to

provide real technical expertise to States who request help from the central office.

"Technical assistance" is a term too often used to cover a multitude of sins. Everything that anyone does which can't be labelled anything else is called TA. Well, that's not what I am talking about.

CAP is composed of people who have had direct hands-on experience in the field and now seek to transfer what they have learned from one State program to another. But let me emphasize that CAP people are not the Federal bureaucracy's answer to Typhoid Mary: They don't transmit the lack of knowledge one State has about eligibility error to another State that is just beginning to get it's feet on the ground. Rather, the Corrective Action Project takes the useful knowledge from the State and injects their own expertise to make it even better.

All of these systems:

- Medicaid Quality Control
- Medicaid Management Information System
- State Assessments, and
- The Corrective Action Project

are steps we are taking to help the States assess their own programs and cost-effectiveness. I urge you to find out more about them, to use them, and to let us know what we can do to help you further.

NURSING HOME INDUSTRY AND MEDICAID

There is one particular aspect of health care costs that has me particularly worried: the nursing home industry.

We are all aware that the number of people over 65 years of age in this country is growing rapidly. And while their numbers are growing geometrically, the cost of affording institutionalized care for them is growing exponentially.

Take Medicaid for example. Nearly 40 cents out of every Medicaid dollar goes toward institutionalized nursing home care. That is an alarmingly high amount, particularly when nursing home patients make up less than 8 percent of the Medicaid beneficiaries. But what is even more alarming is that while the proportion of people using nursing homes in our program rose by 6% between 1973 and 1977, total expenditures for institutionalized longterm care increased by 113%.

I believe that the real tragedy of America's health care system is that many long term care patients are in substandard facilities because it is more convenient for society to get them out of the way. Many studies by State Medicaid agencies reveal that a significant number of residents in LTC facilities are there not for medical but for social reasons. Many of them require some assistance in daily living that could be provided in a non-institutionalized setting.

Yet we have not been sufficiently imaginative to find and finance practical alternatives to the either/or situation of inadequate or absent care in an elderly person's own home or the depersonalized (and frequently dehumanizing) setting of a long term care institution.

While I can only discuss this issue in the context of the Medicaid program, you have the responsibility for looking at all the forces that are impacting your State's rising health care bill. I think you'll agree that one very important area to consider in all of this is long term care and how we are both spending our money.

I ask you to look very carefully at how you are spending your health care dollars. The Medicaid program is an open-ended State/Federal program in which the States establish their own priorities. The Federal government then matches State dollars. Looking at the nursing home example, again, seventeen States devote more than one-half of their Medicaid dollars to institutionalized long term care. Alaska, South Dakota and Minnesota spend more than 60%. Now I recognize that the Medicaid program is just for health care alone. But is institutionalized long term care where we want to be spending so much of our health care dollars?

I am in no position to judge, but State legislators must wrestle with these questions, confront the issues, and set priorities.

There are a whole host of less expensive alternatives that are just as effective as institutionalized care: home health services, senior citizen activity centers, voluntary programs, etc. No one alternative has all the answers. But concentrated effort by members of State legislative staffs to turning our thinking from traditional - and costly - modes of care to other possibilities is needed by all of us including those who currently require institutionalized care.

Lastly, I urge you to seek more information and assistance if you think your State could benefit from it. We at the Medicaid Bureau stand ready to help you. Let's do what we can to let Everett Dirksen rest easy. Let's work together on the problems of real money.

II. MEDICAID REFORM: STATE EXPERIENCES

Senator Tarky Lombardi, Jr.
Chairman, Health Committee
New York Senate

THE NEW YORK EXPERIENCE

Medicaid first evolved in New York State in 1966 -- the same year I entered the New York State Senate -- and I have been living with it ever since.

Starting with its passage, we have been reacting continually to crisis situations.

How well I remember April, 1966, when our legislature was warned by the then commissioner of social services that if this enabling legislation was not passed by April 30, about two weeks after it was first introduced, New York State would lose at least \$19 million in Federal reimbursement for the first quarter of that year. I do not believe any of us then in the legislature had any concept of the enormity of Medicaid. An inner sense told me "no", but reluctantly I voted for the program, along with all but one New York State Senator. I advocated medical assistance to the needy, but I felt we were rushing blindly into a massive program that we were ill-equipped to handle. In addition, I was not "sold" on the assumption that the infusion of Title XIX money into our State would curtail State expenses for providing care to the medically needy.

I could have been far more comfortable with the program if I had been assured that the huge Medicaid spending program I visualized would be effectively administered to provide adequate and quality medical care for the poor.

New York State's original Medicaid law, which passed after one brief, poorly attended public hearing proved to be a giveaway program. We had unlimited provision of the basic health services mandated under Title XIX; unlimited provision of all Federally authorized optional services; full coverage for Federal public assistance and State-aided general assistance population; and full coverage for a medically needy category with an eligibility level of \$6,000 for a family of four.

It was not until after the law was enacted that the public panicked. Our constituencies, local governments, health providers and the taxpayers as well revolted. As a result, marathon public hearings were held after the fact. Governor Rockefeller was the opening witness an attempt to set the pace for a program that he hoped would be embraced. Despite the public uproar and vehement statements of disapproval, the law prevailed.

By 1969, however, there was no question that it was a runaway program and New York State could not continue to foot the skyrocketing health bills at such a phenomenal annual increase. During 1969, we started to retrench somewhat, realizing that the system was not what we were led to believe it would be.

Hospitals, nursing homes and health professionals were geared up to service the increased demands. Patients were recruited to enroll for Medicaid. They were literally "coming out of the woodwork." Although a large proportion of our medically indigent were receiving good health care for real illnesses, many others were using hospital clinics for social purposes. Some felt that having a Medicaid card entitled them to go from one facility to another. We were not prepared for the number of people in the system, nor for the abuses that quickly became obvious. It was expected that total health care expenditures would rise with the increased demands, but no one was prepared for what actually happened to prices.

In 1969 I became convinced that the best way to control the system was to require patient participation in their own health care and introduced legislation requiring co-payment for all outpatient care. Federal law prohibits co-payment for inpatient care. I was unsuccessful that year, but finally, in 1970, the requirement was enacted. The then social services commissioner ignored the law, with the excuse it was too cumbersome to put into place. Eventually, it was repealed at the insistence of the social services commissioner who claimed it was unworkable and that Federal law did not allow co-payment as provided in our law. (Ed. Note: Mandatory services for the categorically needy must be provided without charge to the recipient, under Federal law.)

Now a study by Rand Corporation economists suggests that free care pushes demand about 8 to 15 percent higher than it would be if the patient participated in the program, with a co-payment of 25 percent. Twenty-five percent might be somewhat high but a co-payment mechanism would give the health care user the incentive to be a "prudent buyer."

We cannot place all the blame on the providers and the users. Government encouraged expansion and increased utilization. Federal monies were easily accessible for construction. New York State established low interest loan funds for construction and reconstruction, for both non-profit hospitals and nursing homes. That money, too, was readily available, although it has dried up also. And, even with our certification of need law on the books since 1964, we had a "bricks and mortar" epidemic and the hospital and nursing home industries were expanding at an incredible rate.

New York State continued to outpace the nation in number of beds, length of stay and dollars spent per capita. Here I must agree with President Carter's statement that "more is not necessarily better."

For instance, in 1969 the national total per capita health expenditure was \$294 and New York's was \$374. In 1973, when the national figure was \$441, New York's was \$600. In 1975, New Yorkers spent \$758 while \$547 was spent nationally.

Medicaid expenses in New York have risen from \$607 million in 1967 to \$2.9 billion in 1976; 34.4 percent of the Medicaid dollars was spent for hospital care; 35.5 percent for nursing home care; 11.3 percent for clinics and outpatient care; 6.5 percent for doctors and other professionals; 1.8 percent went for dental care; 3.3 percent for drugs and supplies; while 7.2 percent was spent for all other services. Our limitations must be recognized.

Currently we have approximately 80,000 hospital beds, existing and under construction, while our department of health has projected a need for 68,000 beds in 1980. New York City is grossly "overbedded," and our State health department is desperately attempting to cut back the numbers substantially. A similar situation, but to a lesser degree, exists in areas outside the city. This is one of the most difficult tasks facing the administration today.

As legislators and legislative staff members, you all know it is easier to start a program than to curtail it. For instance, in the early 70's, Medicaid mills became prevalent, largely in New York City. These are neither certified nor licensed facilities, but are practices started largely by entrepreneurs in medically deprived areas. No one knows how many mills are in existence because they are not listed anywhere and they seem to move rapidly from place to place.

I am sure you have all been hearing about the "ping-ponging" of patients. It is not uncommon for a person to go in for treatment of a common cold and be seen by a podiatrist, a psychiatrist and a dentist in addition to being given a few aspirin for his cold. The providers usually are paid a percentage by the owner and it is to their financial advantage to "over-treat" even though it is morally wrong.

Our legislature is now working on solutions to curtail these abuses. What is the best way to do it? Conceptually, we all agree careful regulation is necessary. The bill currently under consideration requires licensure for these facilities. Is this the best control mechanism? Once a license is issued it is exceedingly hard to "lift". Both legislative bodies and the governor's office

as well must reach an agreement on the best approach to put an end to such abusive Medicaid practices.

Abuses in the nursing home industry in New York have become notorious. I am seriously concerned that we over-reacted as a result of horrendous exploitations by a few. I believe that most people in the industry are honest and sincere.

In 1975, we reacted again in a crisis fashion and enacted nursing home legislation which was implemented by overly restrictive rules and regulations which were not within the legislative intent. My biggest fear is the effect on patients. Much work, including cleaning up some of our present laws, remains to be done to assure that the elderly and infirm who have no choice in their institutional confinement will be cared for properly and that their physical, social and psychological needs will be met. We know that some patients are placed improperly and, in a sizable percentage of cases, we are paying for a higher level of care than actually is needed by the patient. This must stop.

We will be considering, this month and next, legislation submitted by the governor that would require placement assessment of all persons applying for admission to long term care facilities, regardless of personal resources. The rationale is that within a short time a self-pay patient exhausts his resources and becomes Medicaid eligible. However, we must also consider the freedom of choice of the more fortunate. If they choose to enter a nursing home and can afford to pay the costs themselves, can we morally prevent them from doing so?

In addition, some of the standards imposed on long term care facilities, either by government or by the industry itself, have resulted in exorbitant costs we can no longer afford to pay. Over the years, I have been seriously concerned about exceeding our ability to pay. Do we need paid basket weaving teachers in our nursing home programs? What has happened to the volunteers who used to give their time and talent to make life in a nursing home more pleasant? Perhaps, because government reimbursement was easy to come by, nursing homes hired professionals to do the work formerly done by volunteer groups. It is time to revert to the "help thy neighbor" concept.

Abuses in the long term care industry must stop. At the same time, we must reimburse appropriately for needed services and set priorities for our tax dollars.

Perhaps the best way we can care for patients who need long term care is to expand the delivery of home health care. I have introduced legislation that would basically create "nursing homes without walls." This has been enacted in New York and is being

implemented, with a 75% restriction for such service. This proposal would allow long term care facilities to deliver nursing home level care to patients who have been approved for long term care but who have also been considered medically eligible to remain at home if proper care was available to them there. This plan, of course, is not for everyone. First, the patient must have a home to stay in and a family willing to have him there. A budget, in accordance with his needs, would be established by the local social services district, not to exceed 80 percent of the annual cost of a nursing home in the same area. Here is an example of how this budget would fluctuate monthly. If the average monthly nursing home rate was \$1,000, the monthly budget would be \$800 -- or a maximum of \$9,600 for a year. If it were determined that the patient's actual necessary care would cost \$600 a month, he would receive a paper credit of \$200; then, should his condition worsen and more care become necessary, the money that was saved in previous months could be used.

Long term care facilities and hospitals desiring to provide this type of service first would apply to the local health services agency and then to our department of health for approval. Need for the services, as well as the ability to provide it, would be taken into consideration before approval was given.

I can see this as a way of reducing waiting lists for long term care beds, as a humane way of treating our elderly and infirm and as a cost-saving mechanism as well. We have high hopes for passage this year and appear to be gaining widespread support. [1]

Now to hospitals -- I am not sure whether or not New York's situation is unique. Our laws now are parallel with the rationale used in setting Blue Cross and Medicaid rates. Prior to 1976, the problems were surmountable. But with the severe fiscal crisis that loomed before us in late 1975, it was obvious that curtailment of government funds in the health delivery system was essential. However, for every \$2.00 in Medicaid money taken out of the system, \$3.00 of Blue Cross money is also removed. Hospitals, even after cutting back services and personnel, began operating at large deficits. Some New York City hospitals went bankrupt. Others are on the verge. This is a "Catch 22" situation because the public pays both ways. Tax money subsidizes Medicaid, and Blue Cross premiums are paid generally by both the employee and employer. Industry is hurting and the workers cannot afford higher health insurance premiums. Do we "uncouple" the formulae and hope that rates will not skyrocket? Or, do we keep the status quo and watch the institutional health delivery system fall apart? This is another critical problem now faced by our legislature.

Last year the legislature reluctantly passed legislation submitted by the governor that cut Medicaid. Almost every section

of the law has been challenged in the courts. Several parts are still in litigation. Although the anticipated State savings as a result of that law were \$70 million, no one has been able to determine exactly how much was saved.

It should be the responsibility of the appropriate legislative committee in each State to oversee the laws. If some laws are not being properly implemented or if legislative intent is being distorted, legislators must take corrective action.

We must assure all citizens, rich or poor, that quality health care is available for all. We must also assure them that unscrupulous providers cannot "rip off" the sick and elderly who are unable to protect themselves. We must also assure them that they, as taxpayers, are getting their money's worth.

The time for buck-passing is long since gone. The Federal government must lead the way, and the States' legislatures and administrative bodies must join the Congress and the President to halt abuses and prevent reoccurrences of the patterns established in the late 60's and early 70's.

State legislatures cannot do this alone. What has happened in New York last year will happen in another State next year -- or in three years. This is a national problem and, in order to reach a workable solution, all levels of government as well as hospitals, nursing homes and the entire medical profession must work together toward achieving the same goals. Only then can we be certain that wherever we go in this country, our sick -- poor or rich, young or old -- will receive quality health care delivered in the most economical manner.

Notes

[1] As passed the law specifies a 75% cap. See "Summary of Nursing Home Without Walls Law" in Section III.

Medicaid was enacted in 1965 to accomplish two objectives: (1) to end segregation by socioeconomic status in the delivery of health services, and (2) to create access to the mainstream of medical care for the poor by enabling them to select their own private physicians and hospitals.

Twelve years later, neither of these lofty goals has been obtained. The reasons are many. A thorough review of medical deficiencies reveals lessons which must not be ignored as the States move to control and improve Medicaid through legislative oversight and executive action, while Congress ponders Federalization of Medicaid or national health insurance.

In 1976, the Legislative Program Review and Investigations Committee of the Connecticut General Assembly conducted a comprehensive study of the Medicaid program in the State, using on cost containment. In its study, published last September, the committee looked at controls on eligibility, prices, expenditures, and utilization, and found major shortcomings in all areas.

In the area of eligibility, the committee found that annual eligibility redeterminations of the medically needy caseload were not being done as required by Federal regulation. Unacceptable error rates in the cash assistance caseload, Aid to Families with Dependent Children (AFDC), was costing Connecticut millions of dollars annually in medical assistance to ineligibles. The committee recommended upgrading of staffing, improved training, and implementation of a caseload system to help correct deficiencies.

In reviewing rate-setting procedures, the committee endorsed, with some reservations, a new cost-related system of reimbursement for nursing homes. The new system is designed to end profiteering through complex manipulation of investments and fraudulent reporting, practices documented in other States. The committee also recommended that nursing homes only be reimbursed for the level of care required by the patient. Some 20 to 50 percent of Medicaid patients in Connecticut receive skilled nursing care when only intermediate facility care, which is less costly, is needed.

The committee found that understaffing was a major problem in the medical section of the State's Department of Social Services. Overexpenditures were occurring due to lack of controls in the bill processing system and inadequate staff auditing of bills on a post-

payment basis. The committee recommended filling job vacancies and other improvements.

Utilization review was also deficient. Connecticut's Medicaid Management Information System (MMIS), essential to controlling and monitoring costs and utilization, has not yet been developed and implemented. The committee found that the MMIS project lacked sufficient leadership and recommended hiring a full time director to oversee the project.

In summary, the legislative oversight committee in Connecticut found that an increased investment in the management and administration of the Medicaid program was needed to save wasted and unnecessary program costs. In a 17-page cost/benefit memorandum, the committee estimated that \$16.8 million of Connecticut's \$200 million Medicaid program could be saved if \$4 million was spent to improve administrative controls by implementing the committee's 55 recommendations.

Some compliance with committee recommendations has already been achieved. The Department of Social Services has reported significant progress in seeking a full time MMIS director. More staff has been hired to fill vacancies in the medical payments sections, and the department also plans to solicit bids for the private administration of its drug program, a recommendation made by the committee report. Other recommendations are under study or scheduled for implementation when staff is made available.

Whether these administrative changes will result in meaningful cost control remains to be seen. Careful monitoring by the legislature will be required as the Department of Social Services struggles to improve management of the Medicaid program.

Response by the department to some of the committee's commendations show the difficulties involved in implementing major program changes. For example, the committee recommended reimbursement of nursing homes only for the appropriate level of patient care. Although the recommendation seems reasonable, the Department of Social Services staff consider it unworkable because of restrictions in the public health code and the unwillingness of skilled nursing facilities to accept intermediate care rates. Therefore, government regulation of building codes and the collective strength of the nursing home industry combine, in this case, to frustrate implementation of a major cost-saving recommendation.

In another case, the Department of Social Services indicated that it is not prepared to implement a system requiring a second opinion for elective surgery. The department cited opposition in

the medical community as a major obstacle to incorporating second opinions when surgery is elective.

From the Connecticut experience, it is clear that major program modifications will come neither easily nor quickly.

Dr. Henry Foley
Former Executive Director
Department of Social Services, Colorado
(now Administrator of Health
Resources Administration, HEW)

THE COLORADO EXPERIENCE

It was interesting to come back to the State level 3 1/2 years ago and face the love-hate relationship that, I am sure, many of you have had with your large umbrella agencies. On some days we were together and on others we were far apart. But one issue about which we had a mutual concern was the rising cost of health care in the Medicaid program. Let me share with you some of the myths that we were able to dispel; some difficulties that we had as we got down to hard problem solving in this program in Colorado, and our experience with the Federal interpretation of what we have been doing.

First of all, we had the concern that most legislators have with the number of eligibles and how much error there was in terms of recipient eligibility. We resorted to face-to-face redetermination on every client in the State of Colorado and went from 106,000 clients in the month of March 1976, to 91,000 clients this past August. That redetermination destroyed the myth that you are going to prevent rising health care costs. While the number of clients certainly dropped significantly, well over 10,000 in a year's time, the health-care costs themselves were still continuing to increase. The Joint Budget Committee in this State was quite aware that we had to use some other types of approaches.

The approach that we adopted in the inpatient section of our program, a very high cost portion, was to move to a prospective rate reimbursement system. We saw, in our State program, which was approved by the Federal Government several years ago, that there was enough flexibility to move to setting our prospective rate reimbursement coterminus with the overall rise in the consumer price index, not the hospital or medical price indices. The process of doing that engendered a lawsuit on the part of the hospital association in this State. The suit went to Federal court, creating a situation where both administrators and legislators were required to cooperate and did. When we testified before the Federal district court, although the case was not yet fully resolved, the judge was interested in the fact that both legislators and the executive branch of the State of Colorado wanted to continue to provide access to health-care for the eligible poor. The judge's major question was what should be the total outlay for the Medicaid program in the State. He wanted to see both parties, the State of Colorado and the hospitals, negotiate in good faith. He carefully monitored that process and is still monitoring it to see if, in fact, we are doing so.

The complexity of trying to set rates to the consumer price index is very interesting: 1) there was an educational process that had to occur with the staff of the legislature and 2) there had to be education of the judge and others as to what rate setting was about. At the same time there was education for the staff in the Central Office on exactly what we were doing. I'll never forget the day when we were meeting in the Regional Office and someone from the HEW staff said, "You're violating the law." I said, "Now wait a minute and look at what we are doing here." In about 40 minutes we came out of the meeting agreeing that the State was following the law. We had come up with a different kind of system, still consistent with the Federal/State approval plan for prospective rate reimbursement. We have held hospital cost increases in this State to an annual rate of seven percent overall for the last three years since the Federal price controls went off. That has not endeared State legislators nor this Executive Director to some hospitals in the State. However, it was a hard decision that we had to make.

The second area of concern regarding the Medicaid program was the overall management of the programs in regard to patient profiles, physician profiles, signals for fraud, etc. We decided, as have other States, to move toward a Medicaid Management Information System. We convinced the legislature to mandate such a program. The process raises an interesting problem that I would like to share with you. When one legislature makes a decision to move in a contractual situation with the Federal government, it is necessary that succeeding legislatures continue that effort. What we experienced with our next elected legislature was a need to educate new legislators and their staffs about the merits of a Medicaid Management Information System. We had to convince them that this approach will basically check costs, ensure financial access for their constituents, and assure the provision of quality medical services. A Medicaid Management Information System gives to both legislative and executive branches the information needed to assess whether or not access is being continued and whether the types of services being provided are worthwhile.

The third option that we chose in the area of medical costs in our Medicaid program was one of emphasizing provision of health care services to persons in their homes. This means that we need a closer examination on the administrative side of how we are accessing home health agencies. We also need an administrative assessment of the experimental development of community care organizations where the responsibility for providing care to persons in their homes is placed at the local level. Although this is characterized as social service, it still legally qualifies under medical services. The line is very fuzzy between what you call a social service and a medical service. Often, both are termed health services if they are insuring the adequate health

maintenance of persons in their own home or community.

An additional major focus in our program is the area of nursing homes. Any administrator worth his salt should go to the Secretary of his State and find out how many nursing home operators are contributing funds to State legislators. One of the interesting games that occurs at State levels and in the U.S. Congress is the "ranting and raving" about nursing home expenditures and nursing home abuses. Then when you move for legislation to check those abuses, to make sure that the financial needs of patients are protected, you find it very interesting to see how the legislature votes. This year, I was able to sit down with a public contributor list and look at the committee that this bill was going to go through. We had major legislation sponsored by the Attorney General's Office, the District Attorneys of the State, the judges, the Department of Social Services and the Department of Health. I would say that the bureaucracy and the legal authorities were fairly well coordinated. Legislation went to the committee which had the responsibility for it. The negative vote did not surprise me.

To get the kind of laws that will be helpful to administrators in their effort to assure that some of the care we are to provide through Medicaid to the nursing home population is being given, will necessitate using the press to identify specific abusers in the nursing home industry. It takes an aggressive enforcement activity, usually on the part of the Departments of Health and Social Services, to be sure that the rules and the regulations already on the books are used. The criticism is that we are overregulating. Overregulation is not the case. However, real enforcement is beginning in this State. We have moved to unannounced visits, with crack teams looking at both the quality of care being provided and the financial status of nursing home patients' needs accounts. The major program that will have to be revised in considering national health insurance in any bill before the Congress, is the way we handle the nursing home sector. We must finance nursing home care on a different basis and use different types of regulatory mechanisms in order to control this type of program.

Another area of concern is that of fraud and abuse. Eighteen months ago we set up an office of investigations and saw that the priority was the medical care area. To do a crack case on a physician, pharmacist or nursing home to establish enough information for that data to go to the grand jury or to a district attorney for prosecution involves many man hours. For example, in Project Integrity, each State has 25 physicians and 25 pharmacists to monitor. An indication of abuse by a doctor or pharmacist takes 4,000 person-hours to investigate. If we singled out five doctors and five pharmacists in small States, we would get the same impact

on the medical community as if we had singled out 25 pharmacists and 25 physicians. If you really want to ensure that fraud does not occur, you are going to have to pay for the staff. The staff needs to do a proper investigation so that the cases taken to a grand jury or to the DA are not thrown out. We are suggesting that States undertake fewer cases, use them symbolically and use the regulatory information that our Medicaid Management Information Systems generate. When there are indications that there is a provider who is greedily abusing the system, then that information should go automatically to the Medical Board of Examiners and to others. In this manner, we will begin to use the doctor's community on the State level as well as other types of peer groups to begin some self-discipline. The information could be shared publicly in a useful way rather than for great press releases. The public sharing of information should be a regular activity by the Federal government and the States.

It became clearer as we moved along that there is no way to single out the Medicaid program as the major cause of cost increases at this time without looking at the other kinds of payers in the health care sector itself. It makes no sense for my department to have the only rate control structure in the State. The legislature, recognizing that, moved to establish a rate control commission and looked at the experiences of States like Massachusetts, New Jersey, Maryland, and Washington. All of us need to look at how we control the rates across the board, not only in the Medicaid and Medicare sector, but in the private insurance sector as well. This State established a rate control commission which will build on some of the advances other States already have achieved. Colorado also is looking at how to link the rate control commission, the Medicaid program, the Health Systems Agencies, and the Professional Standards Review Organizations together with the right control structures. The linkage for these agencies and programs has to be set up by the legislature and at the executive level in each State. Negotiated incentives have to be offered for that kind of linkage to work.

The two final issues I would like to discuss with you are those of the working population which is not now covered, and the level of knowledge in State legislatures. The Medicaid program is certainly a source of pain to both legislative and executive branches when it comes to appropriations. It is interesting to note that in this State most of our legislators, Republicans and Democrats, are discussing how they can finance access to health services for the working poor. We do not presently have a medically needy program in the State. So, at a time when we are talking about health care cost containment, we also are considering the expansion of a program to cover a greater portion of the State population. We estimate that, in our first year of operation, we will spend approximately \$35 million in that program, 50 percent of

which will be State funds. From a political standpoint, the cost would prevent any other new programs in the State of Colorado. It is unlikely that most legislators would want to trade off their specific interests in exchange for an expanded medical care program.

The second problem is the turnover in legislative staff. I would suggest very strongly that while there is need for competency in the executive side of the Medicaid programs across the country, there also is a need to make sure that legislative staffs are very competent in dealing with the Medicaid program and its complexities. In Colorado, we turn over our staff on the Joint Budget Committee every year. Each year we inherit an analyst who knows very little about Medicaid or health. I recommend offering positions to people who know something about the health care sector and will stick with the job for a while. If you feel that the person is going to be bought off, since the chance for corruption is quite great, move that person after three or four years. However, hire someone who is qualified to do the job. If we are going to be serious about trying to contain health care costs, provide good services and prevent fraud and abuse, then we are going to have to have qualified people in both branches of government.

As far as the State legislatures go, much attention has been directed toward solving the Medicaid problem through policy changes designed to effectuate "cost containment" (a stem in the rise of health care pricing and utilization) but not enough to the important area of providing legislative oversight of the administrative operation of the State's Medicaid program. Hence, I would like to sketch a brief outline of some of the things needed to make the administration of the State's Medicaid program less of a "bill-paying" function (which works so well that bills are often paid two or three times) and more responsive to legislatively established program goals and also legislatively established maximum spending levels.

IMPROVING THE LEGISLATIVE PROCESS OF REVIEW AND OVERSIGHT

These are some of the things State legislatures can do to become active cooperative partners in a checks-and-balances system while at the same time assisting in the control of spending (in this case Medicaid spending) before the situation becomes unmanageable and the only alternative appears to be pouring more "good" money after "bad".

1. Clarify legislative intent about the expectations from the Medicaid program and also about program expectations. Put these statements of policy into the law.

It is surprising how many States have gotten away from "statements of intent" and "statements of policy" because it clutters up the State code. As much time should be devoted to describing the intent of legislation as is spent in drafting the legislation. If the intent of the sponsor and the problem being addressed is not clear, then neither will the bill drafted to address the problem be clear.

2. Use statements of intent throughout the appropriations process -- either in the bill(s) itself or in a "following" joint or concurrent resolution. If you intended nursing home reimbursements to be \$26 per day as a maximum, and these were the promises made to the industry when you set up your formula for reasonable cost nursing home reimbursements, then say so.

3. Set up appropriate "safety valves" in your appropriations bills so that if something goes wrong in the delicate balance of the budget there will be "trigger mechanisms" notifying legislators of the upset in the balance and, at the same time, will set into motion the appropriate cost curtailment mechanisms that have been pre-established by the legislature. The legislature then will not find itself called into special session only after all else has been tried by the executive and failed and when the only solution is a quicky deficiency appropriations bill. Two kinds of programs need special attention in this regard.
 - a. Programs funded through State and Federal match -- especially the welfare programs with open-ended Federal matching;
 - b. Programs funded through complicated formulas dependent upon external variables such as enrollment, number of recipients.
Medicaid qualifies in both respects and therefore should be especially amenable to the establishment of necessary "safety valves."
4. Use the appropriations bill and the budget to establish mechanisms for monitoring (a) the achievement of program goals, and (b) spending. Use it to set up the levels of control needed by:
 - a. Using line-times to spell out the level of program control desired (control by provider group or by recipient group or by service provided, setting up ceilings as appropriate and safety valves with priorities for reductions);
 - b. Appropriating State and Federal moneys (only 13 States do);
 - c. Being extremely cautious in jumping further into so-called budgetary "advances" that are really products of executive thinking designed to expand executive powers at the expense of legislative exercise of the appropriations power (e.g., lump-sum appropriations of various kinds, program budgeting, PPR).

5. Improve the legislative oversight function. This should be a non-session function, or at least it should be co-terminus with major session activities. The choices for giving it a separate identity includes:

- Devoting one day a week non-session day to "oversight";

- Full-scale oversight in alternate years;

- Fall session devoted to review of programs.

Establish institutions unique to this function. Highly developed bill-passing function is not suited to oversight. Committee structure and adversary proceeding setting are not conducive to cooperation - creates antagonism. Oversight needs continuous on-going review. Bill passage and legislative process institutionalized to facilitate it are not conducive to exercise of oversight, not continuous, not recurring. Establish adequate reward structure to encourage participation by legislators in institutions developed to formalize oversight and to eventually establish that function as co-equal and co-important with policy-making (bill passing).

Medicaid program has all the ingredients to make it the saleable commodity for legislative review and effective oversight. Some supporting points are:

- General public (taxpayers) unhappy with rising costs, cheaters among recipients and providers, excess utilization;

- Providers unhappy with red tape, delayed payments, government controls on prices and reimbursement;

- Legislature is by nature "crisis-oriented" and Medicaid costs have risen to crisis stage in many States;

- Legislators are fed up with a system that does little more than pay bills-sometimes two and three times.

6. Conditions are such to make Medicaid an ideal candidate to apply the three bywords of current gropings toward making the bureaucracy accountable to the public through its representatives:

- Zero-base budgeting

- Sunset laws

-- Performance auditing

But these have been oversold, and real meaningful legislative oversight will create its own unique institution.

7. Ask the difficult but basic questions and exhibit the political courage to implement the policy dictated by the answers. Take the program apart bit by bit and determine which pieces do not work and be prepared to discard or replace many of them.

- a. Do you want and can you afford a public system providing more free services than private contributory systems?

Provision of all of the optional services including physical therapy (by non-licensed persons in some cases), and the full range of dental services, to name only two, far exceeds the provisions of the most liberal private contributory group health plans.

- b. Can we leave the choice between expensive hospital outpatient health care and less expensive private practitioner care at the discretion of the non-contributory patient-recipient?

- c. How long can payments be made for government services (which health care really is -- a government service provided by government contractors) without any standards or guidelines of expected results? What other program offered by government does not hold the private contractor to any kind of standard before payment is provided -- no competitive bidding, no true contract approval process, no prescribed performance expectations?

- d. How long can a monopolistic industry remain virtually unregulated? Regulation of prices are applied with varying degrees throughout the country, but almost universally only to government payments so that controls over that sector simply lead to increases in prices charged to the private sector, which becomes self-defeating as the system then closes down on participation with publicly-supported patients. Only during the years when Federal wage and price controls were applied to the entire health care industry was there true cost containment. Some laudatory efforts are also underway in States like New Jersey,

Connecticut and Maryland, where health facility licensing and regulation agencies have been established.

- e. Are certain segments of the health care industry reaping unjustified profits - profits not justified by the services rendered? Are there some nursing homes which should be shut down? Are there others which, through clever corporate layering, contract with themselves to provide linen services, laboratory services, pharmaceuticals, artificially inflating "reasonable" costs? Who are the principals of these homes?
- f. Are the most cost-consuming participants in the provision of health care services -- the hospitals -- overprotected? Why has virtually every State's attempt at controlling government reimbursement of hospital charges met with a stone wall in either HEW or Congress? How can effective cost controls be established if the hospitals are not to be affected in any way in their ability to set whatever charges they deem "reasonable" and expect prompt payment without question?
- g. How long can States and the Federal government afford a non-participatory plan which provides no incentives for reducing unnecessary utilization of health care services? The providers have no incentives presently to reduce utilization -- quite the reverse. Recipients do not participate whatsoever in paying a part of the costs and thus can "physician shop", use the health care services as an excuse to get out of the house, etc. Co-payments are used in some States but they are limited to the provision of optional services and must be nominal.

The time has come to consider reopening the Federal legislation, if necessary, to provide for a recipient participation program that might be the most effective means of reducing unnecessary utilization, also to provide necessary meaningful recipient participation in reviewing provider billings or to whether services were charged at the quoted prices and received by the recipient himself.

The most likely model for such an approach is found in the present food stamp program.

- Recipients could be offered the option of purchasing health care stamps or coupons, but once in the program could not withdraw.
- Only certain described mandatory health services would be provided free of charge although, even here, a minimum participatory fee might be established;
- Eligibility for the dollar value of coupons could be based upon size of family and age of children and adults in the family unit and actuarially predetermined;
- States could be given the option of increasing the grant level to accomodate average expected participation (now prohibited under Federal rules with respect to co-payments) recognizing that considerable savings would still be achieved through reduction in the utilization of services and the audit trail provided for medical provider billings;
- This approach would recognize that recipients are not children and should be encouraged to use health care services wisely;
- The approach would leave recipients with the free choice of how to best utilize their available health care budget including, if they wished, "saving up" for elective surgery;
- States would not necessarily have to wait for the Federal government to experiment with such an approach; they could perhaps utilize it in their "medical only" or "medically indigent" program or apply for a demonstration project to test it in a limited area or seek a waiver of Federal rules to test the idea;
- While this suggestion has problems it is probably worth legislative consideration as one of the few solutions that has attempted to look at the total problem and not just pieces here and there such as many of the "band-aid" solutions have done.

- h. Have States now come to realize that the vast bulk of Medicaid spending is in the area of the provision of long term care in hospitals, nursing homes and intermediate care facilities and that meaningful cost containment must not only include but emphasize cutting costs in these areas?

In many parts of the nation, Federal encouragement of hospital building has resulted in facilities being used to as little as 20% of their capacity, while studies in various states have found 50% or 60% utilization to be the norm. At the same time, highly specialized and expensive intensive care units, units for open heart surgery continue to be added to each and every hospital in metropolitan areas whether they can be cost-justified or not.

Solutions must be found to prevent further over-building of long term care facilities and to reduce excessive staffing and equipment purchases which are not cost-justified. At the same time, States can develop meaningful alternatives to institutionalization in order to cut back on long term care spending.

Some of these alternatives have been opened up through the issuance of an HEW memorandum in 1976. Medicaid financial participation has been authorized for the development of "day care centers", "day hospitals", therapeutic day treatment services and night care programs.

Distinguishing features of a day hospital are emphasis upon rehabilitation and restorative services in a day hospital, but it will nearly eliminate the costly room and board function of the 24-hour facility and integrate the day hospital with the patient's family and with the community. Day treatment plans would be for less complex medical needs.

Target populations are the Medicaid eligible, chronically ill, elderly or other disabled adults who, except for the availability of a "day" program, would be placed in a long term care institution, or who are unnecessarily in nursing homes or ICF's. But, in order to be eligible for Federal participation under the "clinical" provider category, States must set up standards for providers of services under these models.

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THE CALIFORNIA EXPERIENCE

Medicaid was created in 1965 by the Congress through the Title XIX amendments to the Social Security Act. To me as a physician, the law represented a landmark step to provide adequate health services to the poor.

Hopes ran high. For the first time, a mechanism was created to purchase a wide range of services in the private sector for welfare recipients and others of marginal income. This newly created access to the "mainstream" of medical care would supposedly eventually eliminate a dual, segregated system of services to the poor. State and local governments were provided this opportunity by making available to them substantial new Federal financial assistance to ameliorate the growing pressure on local tax revenues to pay for adequate health services for those unable to pay. Participation by the States was made optional and a predictable pattern of use of Federal resources emerged.

Urbanized, industrialized and densely populated States -- such as New York, Michigan, Illinois and California -- participated eagerly and on a grand scale. Smaller, poorer and more conservative States were more cautious and less ambitious in scope of covered services and in the level of eligibility adopted under Medicaid.

Consequently, the larger States consume a disproportionate share of Federal dollars in comparison with smaller States.

Because a standard of eligibility required a means test, continued economic segregation of the poor was preordained and the Medicaid program became inextricably tied to welfare -- a characteristic which in retrospect doomed the legislative goal of socio-economic integration in the health care system.

After ten years, the actual performance of Medicaid warrants extremely searching evaluation and complete candor in regard to its deficiencies, as our nation prepares to move toward an expanded commitment to some form of national health insurance. The old adage has never had a more appropriate application: whoever ignores history is doomed to repeat its mistakes.

In January, 1976, a report on Medi-Cal, the Medicaid program in California, was issued by the Commission on California State Government Organization and Economy, popularly known as the little Hoover commission because of its cumbersome official name. This is

a long standing commission, independent of the legislature and executive, which performs watchdog functions over State programs in California. This report is somewhat unique in that it attempts a comprehensive review of all major policy issues now incorporated in the terribly complex Medicaid program; and, as is appropriate for such a commission, the report is highly critical of Medicaid, holding that many of the basic premises of the program are untenable and that in its present form it simply defies adequate management by anybody. I will attempt to cover its highlights after listing for you the scope of issues addressed in this particular report.

We dealt with financial resources, cost sharing, dynamics between local, State and Federal government; with the intricacy of cross-over funding into programs delivering mental health services, drug abuse services, etc.; problems of forecasting budgets accurately; the issue of administrative costs as compared with service costs; the complexity of eligibility standards and processing; discussion of the benefit structure and rates and fees for services rendered; a description of the types of providers working in the program and their pattern of provision of care, with specific comments relating to fees for service by private practitioners; to prepaid health plans, to county institutions, to university medical centers, and to medical care foundations, which had their birth in California. We dealt, more extensively than in the past, with consumer experience with various types of providers in Medicaid; with the great and growing concern being shown about data acquisition and processing at the State level; with emphasis on lack of provision of controls, in the areas of quality of health care being provided, the utilization of services, audits, edits, and fraudulent activities within the program; and finally a section was addressed to the problems of program planning and evaluation at the State level for Medicaid, with the comment that so many problems seem to afflict the hectic attempts at management of this particular program that it seems everywhere to suffer for the lack of hard evaluation or planning, which would enable us to get away from some of the agonies we are experiencing with it now.

California implemented Medicaid in 1966. The legislature at that time articulated three interrelated goals: one, the end to segregation by socio-economic status in delivering health services to the poor; second, creation of access to the mainstream of medical care for the poor by enabling them to select private physicians and hospitals; and finally, conversion of county institutions previously dealing only with the poor into community health centers by changing their names and admitting private patients so that they would no longer be identified solely as institutions serving the poor.

Ten years later in California none of these lofty goals have been attained. The reasons are many, and a thorough review of the deficiencies of Medi-Cal/Medicaid must be undertaken before the Congress moves either toward Federalization of the Medicaid program or toward a broader program of national health insurance.

A severe shortage of physicians and other health resources persists where poor concentrate in both urban and rural settings, in spite of very large expenditures under Medicaid. Large public or charitable hospitals are still characteristic of the inner city and urban centers. These hospitals serve only the poor, with few exceptions; consequently, they bear a stigma and do not attract patients who are able to pay for their care elsewhere. Low income patients who are patients who are not eligible for public care tend to rely on their community's non-profit charitable or religious hospitals.

A significant portion of private physicians do not participate in Medicaid for a variety of reasons -- lower than customary fees, constraining regulations, or reluctance to mix lower income patients with middle income patients. The pattern of participation by private physicians in Medicaid is concentric in character: a very high volume of participation by ghetto based providers, a middle level of participation on the fringes of the ghetto, and a low volume of provision in affluent suburban settings, which attract a surplus of all types of physicians except in the specialty of family practice.

Medicare and Medicaid are seriously marred by the provision of excessive and unjustified service of all kinds. Recurrent scandals involve unscrupulous physicians, hospitals, nursing homes, drug stores, laboratories, medical equipment dealers and various other providers -- these scandals range from shoddy practice to outright fraud.

The rate of expenditure in Medicaid in California has consistently exceeded estimates by a wide margin, creating a State fiscal crisis which is creating great concern about the integrity of other essential State services. The factors which are at work in this unrelenting rate of inflation are, again, numerous and complex; but they include at least these: inflation in the cost of all types of health service, an inflation fed by the investment of public monies through the Medicaid and Medicare programs; the provision of services previously not made available to the poor; growth in the size of the eligible population; excessively high costs of processing and keeping current eligibility status; extremely high cost of fiscal intermediary processing of fees for procedures performed; the cost of provision of a high volume of services which are not necessary; the high cost of institutional care in both acute and long term facilities, which under Medicaid

in California show utilization rates that are much different, much higher than in the population at large (much of the utilization appears to be inappropriate); the high starting cost of prepaid health plans, especially those of questionable integrity; the losses incurred at the hands of providers engaged in defrauding the program.

The recession, and unbridled inflation in health services have combined to add an additional burden on State and local government. Working families have been laid off, quickly becoming vulnerable to medical expense because of a loss of work-related insurance coverage. When major or multiple illnesses strike these families, they rapidly deplete their resources and cannot afford care, which then must be provided by local government or charitable institutions.

In the early days of Medicaid in California, county institutions were able to improve the scope and quality of all their services with the Federal matching assistance. The influx of these funds permitted these institutions to improve staffs, expand services, improve equipment and buildings, most of which was accomplished essentially with State and Federal matching funds. The ability of a portion of the poor to find care elsewhere in the private sector at the outset of the program was also beneficial to the public institutions, since they suffered at that time from clearly excessive caseloads. These benefits, however, were relatively short lived in our State. The growth of the indigent population just above the Medicaid standard increased pressure on the county institutions, which must provide care not paid for or not covered by either Medicaid or private insurance. This population is not known as to size, but it appears that it actually exceeds in size the eligible population on Medicaid - a population approaching two and one-half million to add to the two and one-half million that are at one time or another using Title XIX. County institutions still provide a significant portion of care for Medicaid eligibles, as well as for these marginal families.

The stark realities of Medicaid force these conclusions: Medicaid has not succeeded in desegregating medical care by socioeconomic status. The program has partially accommodated the poor in the private sector, but there are many indications that the accommodation is concentrated among providers of marginal integrity and quality. There is no question that some of the care provided in the private sector is of sound and good quality, but only exhaustive studies of patterns of provision of care under Medicaid compared to care financed otherwise can remove the strong suspicion that Medicaid providers of a high volume of services do not measure up to an acceptable standard of professional practice in either the office, hospital, or long term care setting. A summary of major issues calling for reform is hereby presented.

The Eligibility Standards: In California, a relatively generous standard, by national comparison, is nonetheless too low. The population just above Medicaid standards probably now exceeds in size those who are eligible. The eligibility process in California, and I'm sure elsewhere, is far too complex. At least four categories of eligibility are in use in making judgments about indigent families: (a) whether they are on welfare, (b) whether they are linked to welfare but not in need of welfare assistance, (c) whether they are indigents without linkage to public assistance, and finally, (d) whether they are county indigents without any State or Federal financial participation. The eligibility process is vested in the State Department of Benefit Payments (welfare), which is detached administratively from the Department of Health. The eligibility errors in our study were numerous.

In addition, and perhaps even more significantly, there has been little effort by the Department of Health to analyze the demographic characteristics of the eligible population, to do studies of length of time eligibility is maintained, how long people remain in each of these categories, or to study patterns of residence or patterns in the use of covered services. No effort has been directed toward study of case management or treatment outcome.

Millions of dollars are literally being poured down the drain to process these various eligibility categories, and yet there is considerable indication that the cost of that eligibility process is probably more than if care were provided to the few marginal families that are excluded by that process. There is scant evidence that individuals or families able to afford medical care will either cheat on eligibility standards under Medi-Cal in California or go unnecessarily to public institutions for care which they can pay for independently.

There is a crying need to simplify and standardize the eligibility standard and process. If eligibility could be conferred for one year, an enormous amount of fruitless, repetitive and expensive processing would be eliminated and the costs shifted to the provision of services. Voluntary surrender of identification cards would be required with a significant change in economic status.

Such an experiment in eligibility can expect to be greeted with considerable skepticism, but should nonetheless be tested.

The need for experimentation in eligibility is illustrated by a single, startling statistic from our Hoover commission study: in 1975, the cost of identifying 160,000 recipients per month eligible

for medical needy only and medical indigent categories was \$76 million! This is an outrageous waste of limited resources.

The adoption of a national compulsory health insurance program is the most feasible way of eliminating almost completely the cost of eligibility determination. Elimination of this would literally save billions of dollars nationally.

The Benefit Structure: This must include all essential services, including prevention and periodic screening. Failure to cover any essential service will result in denial of care, which in many instances is more costly than a timely provision, due to increased severity of illness and the danger of lasting disability.

The Reimbursement Alternatives: The fee-for-service system of reimbursement lies at the heart of Medicaid deficiencies; a guarantee of government payment invites widespread abuse. Since it is unrealistic to expect rapid conversion to other methods of reimbursement the States should be required by the Federal government to build and enhance their own ability to do adequate review of patterns of provision of care under Medicaid. The technology of professional standards review is sufficiently advanced to permit a computerized performance review of patterns of provision of service. The States must be able to align eligibility files with paid-claim files so that the specifics of care to eligibles can be directly traced to specific providers.

California, for example, with a very large and complex State health department, is unable to answer the most fundamental questions about the dynamics of the flow of eligibility in the population covered, and they have even less handle on what the patterns of provision of care are. This is because the data base on the provision of care is really in the hands of fiscal intermediaries, and the contracts with those intermediaries are insufficient to insure the kind of review required for adequate management of a program of this complexity. Utilization review, if controlled by the State, can readily detect deviant patterns of provision of service and remove abusive providers from the program with alacrity.

The cardinal mistake under Medicaid was to confuse the freedom of choice by recipients with freedom to provide services in the program. States must have the right to select providers of all types on the basis of the quality of their performance. For years in California we have done this under the crippled children's services, and I see the principle as one begging for application in Medicaid. The burden of litigation to remove unscrupulous providers is simply too heavy for the States to bear. It seems to me that provider contracts conditioned by adherence to State standards should become mandatory, and that provision of care under

Medicaid should be viewed in the public arena as a privilege of the professions and not a right, with recipients free to choose amongst providers of proven integrity.

An alternative strategy for Medicaid is to seek to reimburse providers on a prospective, capitation basis. This approach is variously known as the prepaid health plan, health maintenance organization, capitation funding, prospective budgeting. All those terms amount to the same general idea. There are providers in California, such as county institutions, prepaid health plans, foundations for medical care, university complexes, that are very interested in reimbursement on this basis. The obvious benefit to the State is the likelihood of eliminating the provision of services that are not needed, which are induced by a fee. Nonetheless, such organized providers must at the same time be asked to provide statistical evidence of patterns of provision of service to insure an adequate level of care. They must also provide evidence of improved organization of services to enhance continuity of care.

I believe that we have had inordinated problems as a result of poor planning and administration at the State level and a total misunderstanding of the basic ingredients which make up a prepaid health plan. Just before I left Sacramento, we were engaged again in extensive hearings on some of the problems of those prepaid health plans which have this characteristic: they constitute brokerage houses for subcontracting with a variety of entities to provide "comprehensive" services in a very fragmented pattern. Such multiple subcontracting, often with a non-profit front serving at the primary contractor, is clearly a bad way to approach prepayment.

The litany of abuses in such plans should provide a warning to those of you who are looking at prepayment and capitation and prospective budgeting as a panacea: unethical, deceptive marketing; financial inducement to recipients to join plans; misrepresentation of medical staff available to the plan; failure to locate services within reach of the residence of those enrolled; failure to provide services after hours, weekends, and in cases of emergency; failure to provide either access to a primary care physician or to insure referrals to competent specialists; failure to preserve continuity of care or to provide essential health services to the families enrolled in the plan; failure to organize programs for prevention, patient education; failure to monitor the quality of care, or medical records, or of the patterns of provision of services in the plans for their adequacy by requiring meaningful statistical reports of clinical activities in the plan holding out high risk eligibles for fee reimbursement. It's a rather depressing list of deficiencies, but it doesn't mean that

prepayment has no substantial future in the public sector. But it is a way of commenting on the dangers that surround poor administration and incompetent development of prepaid plans under Medicaid.

I would like to close by listing some issues which I believe have to be given much greater weight by the Congress, not only within Medicaid, but within any national health insurance plan.

Medicaid must pay more attention to the realities which bear on the relationship of location of services to location of residence of Medicaid eligibles. Organized providers must be able to demonstrate efforts to locate manpower and facilities in proximity to residential concentrations of Medicaid eligibles. Such a stipulation would call attention to the need to develop resources in scarcity areas. Medicaid itself should seriously consider a development fund to provide capitalization and recruitment ability to supply facilities and manpower where concentrations of the poor, even after ten years, still suffer severe shortages.

Failure to encourage the development of organized ambulatory health centers in urban centers and to address the scarcity of resources in rural communities is a deficiency which cannot be tolerated any longer. Certainly, no further steps should be taken in the expansion of Medicaid until a development of resources strategy is adopted.

The most important and yet the most neglected aspect of care under Medicaid is what happens to the consumer. We need to build into Medicaid regulations standards for all providers which deal with the following issues of importance to the consumer: location of services; the availability of services after hours and weekends; transportation; language assistance; the system of conveying adequate information to patients on program benefits, the eligibility process, and the rights of patients couched in terms which ordinary people can understand.

The range of services available must include, in my judgment, organized programs of patient education in the maintenance of health; periodic screening; emphasis on ambulatory diagnosis and treatment; and de-emphasis on unnecessary hospitalization and admissions of patients who simply don't belong in the environment to nursing homes.

Continuity of care requires supervision in the use of a vast array of services which are innately confusing to the families trying to use them. The availability of primary physicians as individuals, or in more forms of primary care is essential, so that referrals can be controlled.

The extent to which unnecessary services are eliminated is another area of concern, especially in the appropriate use of hospitals and nursing homes. I think more emphasis in the future has to be placed on family practitioners, nurse practitioners, on middle level practitioners, and various professionals working as teams rather than broken up, dispersed, solo efforts which are so characteristic of the system today.

There needs to be some mechanism for stimulating the development of alternatives to institutional care, such as high capacity, neighborhood-based ambulatory diagnosis and treatment centers, ambulatory surgery centers, extended care programs, day treatment facilities, transitional residential care arrangements, organized in-home health programs. It's simply amazing that we know all about how to do those things, but when one studies a typical State Medicaid program, you are hard put to find many innovations in these directions.

We also need to do something about case management, treatment, plans and outcomes.

Medicaid has suffered as a result of paying too much attention to the rules of eligibility, rates and fees, fiscal intermediary functions and complaints of providers. Insufficient attention has been spent studying the needs of recipients and a system of services which for them is accessible, accountable, available, and acceptable.

An overhaul of wasteful, inaccurate, and disorganized delivery of services simply must accompany any further expansion of financing of health care by the government. The legislature and the administration must pay more attention to quality of care, improved organization of services, elimination of fraud and abuse and insistence upon appropriate settings for treatment.

Many of the deficiencies of Medicaid apply increasingly to the provision of health services to those who are not poor. In a way, Title XIX, carefully examined, represents a kind of microcosm of problems being encountered in the entire field of delivery of health services the entire population. It seems clear that this nation cannot afford a national health system based on the deficiencies we have encountered in both Medicare and Medicaid.

Early in 1975, the Senate and House in Minnesota appointed a select committee to investigate a series of allegations of nursing home abuses. Major findings and recommendations were published later in the year regarding both quality of care and cost containment. The cost containment findings were (1) 50 percent of all Medicaid dollars in Minnesota were going into long term care; (2) the program was growing at a rate of 16 to 19 percent annually -- most growth attributed to long term care; (3) it was impossible to establish who owned and controlled the nursing homes; (4) records presented to the State Medicaid agency were inaccurate and inadequate; (5) there was no incentive in the State for providing alternatives to long term care; (6) no State policy for long term care for older citizens existed -- there was no policy language in any of the statutes.

Looking at the financial side, the State agency has been on a cost-related basis for six years. Staff analysis of net equity and return on equity revealed that the cost-related formula was leading to systematic exploitation by the proprietary homes. They showed dollar totals for cost of capital allowances and property and related expenses approximately double those of non-profit homes. The cost-related formula had assumed the owner would have an average of 35 percent equity. In fact, the formula established an incentive for operators not to have equity in the homes. An impetus was provided, as well, for operators to trade homes since each turnover resulted in increased valuation -- which in turn increased Medicaid revenues.

Some nursing homes would have three sets of books -- one set was for real estate taxes. A sample of approximately a dozen homes in the metropolitan area revealed they were evading some \$4.6 million in property taxes. The second set of books was for State and Federal income taxes, and they paid less than they should have. The third set of books was, of course, for the Medicaid system, and that set reflected inflated property related costs. The accounting fees for those who helped design the bogus financial statements were written off and included in the cost of the Medicaid program. The program also paid for the lawyers that appealed the cases involving violations of State law.

These practices seem to be widespread and pervasive, at least as pervasive as the percentage of people who underpay their income taxes. The IRS says that is 45 percent. It is not that nursing home owners set out deliberately in a criminal way to defraud the government. But they saw opportunities in financial statements that enabled them to underpay taxes and be overpaid on Medicaid.

They took advantage of the fact that we didn't require them to have the same set of certified statements.

The select committee had seven major recommendations for cost-containments, all of which became law:

- (1) To change the entire licensing procedure to identify controlling persons, who would be legally defined and accountable for financial disclosures.
- (2) Medicaid vendors would be declared ineligible for any further Medicaid payments if found guilty of theft, the most common crime.
- (3) False claims for reimbursement would be defined and made punishable as theft. (The concept of theft had to be redefined in the statutes. Some owners were taking food from the nursing homes, actually having the vendor send the meat or produce to their own homes. Previously, under Minnesota statutes, the State had to prove that they intended to take the food, that they did take it and almost had to catch them sitting at home eating it with their families. The definition was changed so that now, if the State can show the intent of diverting those supplies for their personal use, that constitutes theft. On that basis, a greater number of cases can be prosecuted.)

Under the new law, all cost reports must be certified as true by a nursing home official or owner. A vendor who willfully files a false cost report is liable for treble damages. The State wants more than just the money back; otherwise it would be just like an interest free loan.

- (4) The need for a medical assistance investigative unit for Medicaid was apparent. We would establish one in the Department of Public Welfare to identify and investigate possible cases of medical assistance fraud, theft, false filings and false statements by any Medicaid vendor.
- (5) The commissioner would inform the attorney general or the appropriate county attorney when a situation was presumed to be abusive or fraudulent. That is important because there were cases about which the Department of Public Welfare was suspicious, but no direct mechanism existed to bring it to the attention of the attorney general or county law enforcement authorities.
- (6) Changes in the reimbursement formula were recommended which required a very complicated piece of legislation.

The objective, in broad policy terms, was to reduce the incentives on property related costs and to create more incentives for quality of care.

Also, it was decided that the differential between the private and Medicaid rates would be phased out. For a two-year period, a differential of ten percent would be allowed between Medicaid and private rates. In the third year, Medicaid vendors will not be permitted to charge private patients any more than they charge Medicaid patients. This is an important matter of public interest, since the public interest is to delay the process by which people spend their money for care, and thereafter rely on Medicaid.

- (7) The committee encouraged the development of alternatives to nursing home care. The State is now attempting to enlist Federal government cooperation in an in-depth survey of Medicaid patients at the time of placement. Previously, surveys were being done 18 months after a patient had been in a home -- too late to prevent dependence on an institution.

Public Law 93-641 represents a genuine opportunity at the State and subState level to consolidate control of the health system, to coordinate the fragments in health care delivery, to stop fraud and abuse and to change incentives for providers. States should consider giving the responsibility for cost containment to State and subState planning agencies created by PL 93-641. The best model might be to tie licensing of facilities and manpower control at the State and subState levels to the authority for cost containment. Manpower and facilities questions are questions of cost and of the resources going into the system. Ultimately, it would seem best to combine them.

The most effective way a State legislature can stay on top of the Medicaid program is by periodic, timely and informative reports from State agencies. If you don't have these, you cannot have effective oversight. Secondly, the oversight function must be perceived as an essential role of the legislature. Third, the health and welfare committees in every State should review annually the State plan for Title XIX eligibility standards, Federal program developments, total expenditures and results of fraud and abuse investigations. Fourth, PL93-641 must be taken more seriously by legislators. Finally, when there is an advise and consent procedure for gubernatorial appointments, the appointee should be evaluated carefully to determine his or her competence to manage the Medicaid program.

In those States where the legislature is in session only a few months, the legislator has problems with the oversight role. The executive agency people know this and take advantage of it. In Minnesota, there is a constitutional requirement that the legislature adjourn the third week in May. This is detrimental to the legislator's ability to oversee programs effectively.

It is important to change the attitude that States are merely pass-through mechanisms for health programs, originating at the Federal level and intended for local level recipients. The next three or five years are going to be critical for strengthening the role of the State in the area of health policy and planning. In Minnesota, we have begun to do this.

III. STATE ALTERNATIVES TO INSTITUTIONAL CARE

NURSING HOME PREADMISSION SCREENING IN VIRGINIA

By CHARLOTTE CARNES
and ANN COOK

Introduction

In discussing health care services for disabled and elderly persons, three concerns are paramount. They are: (1) the increasing number of elderly persons; (2) the high cost of health care, particularly in long term care facilities; and (3) the increasing number of admissions to long term care facilities. In 1965 there were 18.5 million people 65 years or older in the United States; by 1975 there were 22.4 million elderly. This country spent \$139.3 billion for health care in FY1976—14 percent more than in the previous year, with expenditures for nursing home care increasing from \$3.8 billion in 1970 (or 6 percent of total health care expenditures) to \$10.6 billion in 1976 (or 8 percent of all health care expenditures.) Medicaid's share of this nursing home cost was \$1.6 billion in FY 1970 and \$5.4 billion in FY 1976. An additional measure is the growth of the nursing home industry itself. There were 3-1/2 times as many beds in nursing homes in 1973 as a decade earlier (1.1 million in 1973 compared with 0.3 million in 1963.)¹

One means used to meet the health needs of the disabled and elderly has been the construction of additional long term care facilities. In addition, government programs such as Medicare and Medicaid have been implemented to cover nursing home care. With these measures has come increased placement of the disabled and elderly in long term care facilities. Today, after more than a decade of Medicare and Medicaid, a question still seeking an answer persists. Did the funding available through these

programs create the need for long term care, or did these programs in fact fulfill long unmet health needs? Such philosophizing, no matter how intriguing, does not alter the fact of these health care programs or that they must be run as efficiently and effectively as possible.

In attempting to meet the health care needs of the disabled and elderly through institutional placement, the patients themselves often have not been apprised of alternatives to nursing home placement, or given opportunity to make decisions as to placement—decisions impacting on their own lives. Increased perception of this deficiency by both individuals and program managers has resulted in emphasis on the needs and rights of disabled and elderly persons.

Even the most benevolent and compassionate institution cannot provide the sense of self-determination and independence that an individual can experience in his or her own home. Being placed in a nursing home often means parting with individual freedom and treasured material possessions. It means accommodating one's lifestyle to the demands of efficient facility management and group dynamics, and severing ties with family, friends, and community.

In short, providing care to the disabled and elderly has become costly in terms of health dollars, and complex in terms of protecting the rights of individuals to live as normal and satisfying a life for as long as possible. Historically, our society's attempts at dealing with the needs of the disabled and elderly have created the dichotomy of meeting the individual's physical health needs at the expense of his or her mental well-being. In response to this dichotomy, the Virginia Medical Assistance Program (VMAP) has developed and implemented a Nursing Home Pre-Admission Screening Program. The remainder of this discussion will be focused on this program's background, conception, policy, procedure and current results.

¹Health, United States, 1976-1977, DHEW Publication No. (HRA) 77-1223; Health, United States, 1976-1977 Chartbook, DHEW Publication No. (HRA) 77-1233; Data on the Medicaid Program, Eligibility/Services/Expenditures, FY 1966-77.

*This paper appears in The Journal for Medicaid Management, Volume 1, Number 4, Winter 1977, pp 1-8. Published by the Department of Health, Education and Welfare, Health Care Financing Administration, Institute for Medicaid Management.

Background and Conception

In 1972, when Medicaid coverage of intermediate care facilities (ICFs) as an optional service began, the VMAP included this service as part of its Title XIX program, augmenting mandated skilled nursing facility (SNF) services. Early in 1975, after three years of rising ICF costs, the VMAP began focusing on handling the increasing number of patients going into nursing homes. In 1972, the average cost per day for ICF care was \$15; by 1975, it had risen to \$19.37 a day. The cost of intermediate nursing home care had overtaken and passed inpatient hospitalization to become the most expensive item in Virginia's Medicaid budget. In the past two and one-half years, the VMAP has experienced a net increase of 32% in claims for nursing home care. Payments to intermediate care facilities for FY 1976 accounted for 38% of the Title XIX budget in Virginia, or approximately \$71 million. In FY 1977, Virginia spent \$102 million or 42% of its \$245 million Medicaid budget on ICFs.²

Additionally, since Medicaid in Virginia covers both the categorically and medically needy, every elderly and disabled Virginian is potentially eligible for Medicaid. Demographic studies reveal that the aging population of Virginia has grown from 10.7 percent of the total State population in 1960, to 12.5 percent in 1976, with a projection of 13 percent in 1980. In all, some 621,683 persons 60 years of age and older currently reside in the State.³ Some 53,301 of them are eligible for Medicaid in the "aged" category, and 34,385 are eligible as disabled individuals.

In 1972, 7,083 of the 9,963 nursing home beds licensed in Virginia were certified for intermediate care. In October 1977, some 13,837 of the 14,702 licensed beds in Virginia were certified for intermediate care. Medicaid enrolled persons occupied 63-1/2 percent of those ICF beds. In its SNF program, Virginia has always used Medicare criteria to determine

SNF coverage. Thus, our SNF population represents the more intensive care patient, with the broader definition of Medicaid ICF services directly reflected in the number of beds and patients in the intermediate care spectrum.

Projected expenditures for skilled and intermediate care in the 1978-1980 biennium are in excess of \$200 million for community nursing homes, with an additional \$75 million projected for long term care beds in State institutions for the mentally ill or retarded.

Clearly, fiscal reality and planning demanded that increasing patient admissions from the community directly into long term care facilities be controlled. A consideration of equal importance was the human services issue of appropriateness of care for the institutionalized. Believing that cost containment and quality of care can work together, State Medicaid staff decided to find an answer to these problems—an answer that was compatible with both human needs and fiscal control. We began by considering the Medicaid program's role in contributing to nursing home placements. Funding for placement of the elderly and disabled was readily available for those who were Medicaid eligible, while community based services, such as home health services, were underutilized, and services under Title XX were both underfunded and underutilized. The existence of a medically needy program practically assured Medicaid eligibility for a majority of long term care patients.

In analyzing the issues of readily available funding for nursing home placement and the accompanying underutilization of community based services, several problems were considered. These included: the pressures placed on hospital discharge planners and local departments of welfare by a combination of families, physicians and government requirements to find readily available, funded services for elderly and disabled persons who could not continue to live independently; and the fact that elderly and disabled persons and their families were often unaware of community based services. In addition, the fragmentation of community based services which contributes to the lack of awareness about available services, and the difficulties of threading through the maze of community services were considered. Analysis of these problems led State Medicaid staff to a

²Data on the Medicaid Program; Eligibility/Services/Expenditures, Fiscal Years 1966-78, published by the Institute for Medicaid Management.

³*Alternatives to Institutionalization*, a paper by Edwin L. Wood, Director, Virginia Office on Aging, presented to the Commission on Needs of Elderly Virginians in December 1976.

possible solution: Could a local interdisciplinary team review the appropriateness of nursing home placement prior to admission and thereby enhance the use of community based services for elderly and disabled persons? Such a team should be knowledgeable about local resources that could be mobilized to meet the needs of the individuals screened.

Virginia's Medicaid program is administered by the Department of Health. In July 1976, the Department of Health, working through four local health districts, began to test a nursing home pre-admission screening program. This pilot project was conducted over 9 months in both urban and rural areas. Screening committees composed of a local health department physician, a public health nurse and an adult services social worker were established.

Virginia's relationship with its nursing home providers is built on trust and cooperation. The open dialogue between them has contributed to the success of the screening program. Every Medicaid nursing home in the State was advised in writing that patients in these four localities who were living at home and sought admission would have to be screened by the local committee before actual admission to the facility. Screening was necessary if the patients were Medicaid eligible, or would become Medicaid eligible within 90 days subsequent to admission. This screening requirement became part of the State's admission certification and Medicaid payment would not be made without the screening committee's approval.

A Nursing Home Screening Certificate was developed for use in the program. The form was completed on each individual screened, and although simple in format, included medical, nursing and social information sufficient to create a picture of the "total" person. (See Figure 1.)

The local screening committees were advised to: (1) evaluate the medical, nursing and social needs of each individual referred for pre-admission screening; (2) analyze what specific services the individual needed; and (3) evaluate whether a service or a combination of existing community services were available to meet the individual's need. The committee's assessment of services availability would depend upon whether the needed services existed in the patient's community, the individual's financial eli-

gibility for the service, and whether the service could be delivered at the time and in the amount necessary to meet the individual's need.

Services which could possibly be used to help an individual remain in the community were home health services, chore and companion services, congregate or home delivered meals, adult day care, homemaker services, protective service for adults, and sheltered living arrangements, such as homes for adults or foster homes. If the committee determined that any of these services were needed, the individual was informed by letter and referred to the appropriate provider; the committee followed up to see that the services were provided and the individual was being successfully cared for in the community.

The pilot project showed that 26.3 percent of the 167 individuals screened could be successfully cared for in the community through the use of alternative methods of care. Based on the success of the pilot project, the Virginia Medical Assistance Program initiated pre-admission screening Statewide. The program has received the enthusiastic support of the Virginia Secretary of Human Resources, the Virginia Office on Aging, the State Department of Welfare, the Virginia Health Care Association (the State nursing home association) and the Virginia Commission on the Needs of Elderly Virginians, thereby increasing its acceptance.

Statewide Initiation

Effective May 15, 1977, initiation of the nursing home pre-admission screening program began on a Statewide basis. Orientation sessions for the local health and welfare departments were held throughout the State. At these sessions, background, suggested methodology and philosophy of the program were covered.

As in the pilot project, persons screened are those who are neither in a community hospital nor another nursing home at the time of application. Screening occurs if the individual is, or will become, Medicaid eligible within 90 days of nursing home admission.

Applicants are assessed by the screening committee of the local health department where they live. The committee continues to be composed of a physician, a nurse, and a social



NURSING HOME SCREENING CERTIFICATE

HEALTH DISTRICT _____ HEALTH DEPARTMENT _____

Name of Patient _____ Age: _____ MF _____ MSDW _____
Last First Middle

Address _____

Source of Referral: Self _____ Family _____ Friend _____ Welfare Dept. _____ Other (Identify) _____

RECOMMENDATION:

COMMENTS:

Nursing Home _____

No Change _____

Other Living
Arrangements _____

Home for Adults _____

With Relatives _____

Other (Describe) _____

SERVICES REQUIRED/AVAILABLE:

SERVICES REQUIRED/NOT AVAILABLE:

1. Meals
(Congregate, etc.) _____1. Meals
(Congregate, etc.) _____

2. Chore Services _____

2. Chore Services _____

3. Companion
Services _____3. Companion
Services _____

4. Home Health _____

4. Home Health _____

5. Homemaker _____

5. Homemaker _____

6. Day Care _____

6. Day Care _____

7. Other (Define) _____

7. Other (Define) _____

COMMENTS: _____

Date _____

Signature _____

Man-hours, total _____

Title _____

PRIMARY DIAGNOSIS:

COMMENTS:

Hypertension _____

Diabetes _____

Heart _____

Other Cardiovascular
Diseases, including CVA _____

Cancer _____

Arthritis _____

Other (Define) _____

FUNCTIONAL CAPACITY:

SPECIAL DISABILITIES:

Completely bedridden _____

Up in chair only _____

Ambulates with help
(Device) _____

Ambulates with help
(Other person) _____

Independent
Ambulation _____

Paralysis/Paresis _____

Ambulation _____

Contractures/
Deformities _____

Impaired Vision _____

Deafness _____

Confused/Aberrant
Behavior _____

Other _____

PRESENTING PROBLEMS:

COMMENTS:

Unable to Cope with
Activities of Daily Living _____

Personal Care _____

Care of the Home _____

Food Preparation
(Including Purchase) _____

Menace to Self and Others _____

CURRENT LIVING ARRANGEMENT:

House/Apartment

Alone _____

With Spouse _____

With Child _____

With Other Relative _____

With Friend _____

Home for Adults _____

Rooming House _____

Room and Board _____

Other Institution (Identify) _____

worker from local health or welfare departments. Usually the social worker is employed by the welfare department; occasionally, a local health department social worker will also participate in screening. In addition, the committees have been encouraged to work with other community agencies offering services to the elderly and disabled. In some areas, other agencies which participate on the committee include an area office on aging, a mental health clinic, a private home health agency, a ministerial association, nursing homes, and homes for adults. In one locality, a representative from the community hospital also participates.

Upon receiving a screening referral, usually from the welfare department or family, the committee's social worker and public health department nurse interview the individual and complete the Nursing Home Screening Certificate. The social worker prepares a social evaluation of the individual and the health department nurse evaluates the person's nursing needs, and obtains the medical history. The full committee meets and the evaluations are presented and discussed. If it is not possible for the committee physician to visit the patient and additional medical information is needed, his or her private physician is contacted. The committee carefully reviews each person's case to determine if nursing home admission is appropriate or if he or she can be cared for adequately at home or in the community through local services.

When the committee has reached a decision, the referring agency or individual is informed by letter, with a copy to the local welfare department and to the nursing home, if placement is approved.

Referral and follow up are vital parts of the program. Virginia stresses the human aspect from the initial personal contact with the individual by the nurse or social worker, through referral and follow up. Depending on the type of services needed, either the social worker or nurse will make the referral to the appropriate agency and assure that the individual and family understand how to receive services. In some instances, the nurse or social worker will make a phone call or visit the individual after that to determine if his or her needs are being adequately met. From time to time, the screening committee will discuss individuals previously

screened, to evaluate their progress, and are brought up to date on these individuals' status. In the next year, Virginia hopes to formalize these procedures, as well as increase public relations efforts concerning the program, and availability of non-institutional services.

When the Virginia pre-admission screening program began Statewide, prospective nursing home candidates from facilities of the Department of Mental Health and Mental Retardation were included in the program. These evaluations were conducted by the Utilization Review Section (UR Section) of the VMAP, which substitutes for the local screening committees. In this case the referring facility, a State hospital, prepares medical, nursing, and social information on the potential nursing home candidate for the UR Section. Often the referring hospital indicates a particular nursing home which could meet the individual's physical and mental needs. The UR Section may contact the referring agency if sufficient data on the individual is not supplied. The referring agency or individual is advised in writing of the committee's decision to either authorize or deny payment for nursing home care. If payment is authorized, the appropriate facility is also notified. Transfer from a State hospital to a nursing home is generally on a furlough basis to assure that patients can easily return to proper settings if the nursing home does not meet their particular needs. Appropriate placement of these individuals is, of course, insured by individual professional review teams' regular review of Medicaid nursing home patient care. Without prior UR Section authorization, the VMAP does not make a nursing home payment.

Reporting Mechanism and Program Results

During the first ten months of this program, 1,755 individuals throughout the State have been assessed by screening committees; 395 have been found able to remain in the community (22.5 percent). In addition, 175 patients in State mental health and mental retardation facilities have been screened. Twenty-two percent of these patients were not approved for nursing home care. In these unapproved cases, the most appropriate placement for the individual was determined to be either continued hospitaliza-

tion, or transfer to a licensed adult home or foster home.

To capture information on all individuals screened, and to identify which services were or were not available throughout the State, VMAP receives the Nursing Home Screening Certificate on each individual screened. Analysis to date reveals that the service most often “unavailable” to maintain individuals in the community is companion service (29 percent of the cases), followed by chore services in 22 percent of the cases, homemaker services in 21 percent of the cases, meals in 20 percent of the cases, and adult day care in 18 percent of the cases. Only home health services were available in all areas of the State in sufficient quantity to meet the need in most cases.

The data reflect several reasons that needed services are not available. One is that the individual cannot meet income eligibility requirements for specific services. This is particularly true for individuals with resources above the allowable amount for Supplemental Security Income (SSI). Their ineligibility for SSI renders them ineligible for chore and companion services under Title XX in Virginia.* In many other instances, the service “needed” does not exist in the community. The most striking example of this is adult day care. A third reason for “non-availability of services” is that they may not be offered in sufficient numbers of hours to meet the patient’s need.

As a result of these preliminary findings, Virginia is already exploring ways to increase awareness of community based services, and is working towards increasing alternative means of caring for persons, with the goal of having a nursing home become only *one* option among many long term settings, rather than the *only* option in the minds of many.

Conclusion

At this time, definitive data on cost savings are not available. However, we can make a reasonable projection of estimated cost savings

*This is a Federal problem - one involving legislative requirements that conflict and thus work against the very people the programs were intended to serve, since these eligibility requirements create barriers to non-institutional services.

using figures from a recent GAO study⁴ on home health care, and our best estimate of ICF costs in Virginia. Home health services, of course, do not include such services as chore, companion, homemaker and day care services. If the cost of intermediate care in Virginia averages about \$24.83 a day, a monthly estimate of expenditures for this care would be \$750 (\$25 a day X 30 days a month.)

The GAO study estimates that there is a break-even point, depending on the person’s level of impairment, after which home health care costs exceed institutional costs. The cost of providing care in the home at this level is approximately \$400 a month. Therefore, if an individual could use home health services, instead of ICF services, possible savings of \$350 per patient per month could be realized. If we apply this to the results of the first 10 months of the program, maintaining 395 individuals in the community would save the State \$138,500 per month, or approximately \$1.6 million a year. While these figures are by no means firm and represent only projections, they do indicate potential “savings” that could be realized from pre-admission screening programs such as Virginia’s.

Benefits in terms of social values are more immediately visible, however. Wherever possible, disabled and elderly persons are not being uprooted from their homes and communities and placed in institutional settings. Inappropriate and often unwanted nursing home placements have been delayed or avoided through use of community resources. We have contributed to the well-being of our elderly and disabled recipients and will continue to help them maintain their sense of self-esteem. We believe this can be accomplished only if they remain part of, and feel they are contributing to the community, instead of being dependent upon it. The screening program thus supports directly our goal of assuring the dignity and rights of the elderly and disabled. The emphasis placed on the human factor and the need for support and communication with other agencies are keys to the program’s success.

⁴Comptroller General’s Report to the Congress - Home Health - The Need for a National Policy to Better Provide for the Elderly (HRD-78-19, 12/30/77).

With this program Virginia is also beginning to systematically measure the types of services available in the State, and to identify services required in the community to meet the needs of its elderly and disabled citizens. Based on the need for such services, we are better prepared to actively work towards a Statewide system of community services. The program is important also as a management tool, because it illustrates to us that costs can be contained and the recipient still be well served. We have not yet begun to explore other uses of the data for program management purposes, but have no doubt such situations will arise.

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 - *Ann Cook is the Medical Social Service Director of the Virginia Medical Assistance Program. She received her MSW from the University of North Carolina at Chapel Hill and has been a medical social worker with the State Health Department since 1969.*

Ruth Shepherd
Acting Administrator,
Oregon Office of Elderly
Affairs

OREGON'S PROJECT INDEPENDENCE

A program of home and community services in Oregon is helping some 6,000 poor elderly residents stay in their own homes. State funds provided, per average client, per year, is \$215, compared to approximately \$1,360, State and Federal funds combined, for support of a nursing home bed in Oregon, per year.

The typical Project Independence client is white, female, aged 79 years, widowed, and has less than \$3,000 annual income from private sources and social security. She lives in her own home, probably has been recently hospitalized, and has problems of circulation, arthritis and respiratory disorders. She is partially or totally housebound. Authorized services most needed and used by Project Independence clients in order of frequency of use, are: homemakers; chore workers; outreach; home delivered meals; friendly visiting; telephone reassurance; escorted transportation; health screening and evaluation; assistance in gaining access to health care; protective services; and home health services. Some 90 percent of the total Statewide services are delivered to enrollees in their own homes.

Free service is provided a person in a high risk category whose individual income is \$3,000 or less per year (\$5,000 if living as part of a couple). Eligible persons whose incomes are above those levels pay according to their ability.

The major criteria for admission to the program is that the person must be 60 years of age and in great risk of being placed in an institution within a year. Persons receiving welfare, grants, or services are not eligible for Project Independence. Project Independence workers use an intake form designed to help them assess the needs of the individual and rate the risk of institutionalization for each applicant. (See accompanying form.)

Risk factors include: difficulty with shopping, working, housecleaning and transportation; disabling health problems; limited mobility; problems with vision, hearing or teeth; need for medical care or hospitalization; loss of spouse or relatives; housing problems; and financial difficulties.

If the number of risk points reaches a minimum level established by the program administrator, the applicant is eligible for the program. In the winter of 1977, the average number of points for enrollees in the program was 72, with 67 percent scoring over 60. Early in the operation, 97 percent of the enrollees were

Risk Assessment

		Points		
			Hospitalized	<input type="checkbox"/> 1 Yes
			(Within Last Year) 10 pts	<input type="checkbox"/> 2 No
			Currently Seeing Doctor	<input type="checkbox"/> 1 Yes
				<input type="checkbox"/> 2 No
Problems			Needs Medical Care	<input type="checkbox"/> 1 Yes
Difficulty with/ or	<input type="checkbox"/> Cooking 10 pts			<input type="checkbox"/> 2 No
in need of	<input type="checkbox"/> Light Housekeeping			
1 Yes	<input type="checkbox"/> Chore/Heavy Housecleaning		Current Social Condition	<input type="checkbox"/> Loss of Spouse
2 No	<input type="checkbox"/> Home Repair		(Within Last Year)	<input type="checkbox"/> Loss of Relatives/Friends
	<input type="checkbox"/> Basic Marketing 5 pts		1 Yes	
	<input type="checkbox"/> Shopping		2 No	<input type="checkbox"/> Needs more Social Contact 5 pts
	<input type="checkbox"/> In Home Care 10 pts			
	<input type="checkbox"/> Instruction		Housing Status	<input type="checkbox"/> 1 Owned
	<input type="checkbox"/> Transportation 5 pts			<input type="checkbox"/> 2 Rented
				<input type="checkbox"/> 3 Other
Health			Condition	<input type="checkbox"/> 1 Adequate
Current Condition	<input type="checkbox"/> Circulatory			<input type="checkbox"/> 2 Inadequate 5 pts
	<input type="checkbox"/> Respiratory		Type Dwelling	<input type="checkbox"/> 1 Single Family
1 Severe	<input type="checkbox"/> Digestive			<input type="checkbox"/> 2 Duplex
2 Moderate	<input type="checkbox"/> Diabetes			<input type="checkbox"/> 3 Apartment
3 Mild	<input type="checkbox"/> Arthritis			<input type="checkbox"/> 4 Mobile Home
	<input type="checkbox"/> Stroke			<input type="checkbox"/> 5 Group Quarters
	<input type="checkbox"/> Cancer		Protective Legal Services	<input type="checkbox"/> 1 Yes
Each Severe 5 pts	<input type="checkbox"/> Malnutrition			<input type="checkbox"/> 2 No
Each Moderate 2 pts	<input type="checkbox"/> Emotional Stress		Economic Conditions Benefits	<input type="checkbox"/> Social Security
	<input type="checkbox"/> Other			<input type="checkbox"/> Medicare
			1 Yes	<input type="checkbox"/> Pension
			2 No	<input type="checkbox"/> VA
Mobility				<input type="checkbox"/> Public Assistance
1 Good (Score One Only)	<input type="checkbox"/>			<input type="checkbox"/> SSI
2 Partial		5 pts		<input type="checkbox"/> Food Stamps
3 Housebound		10 pts		<input type="checkbox"/> Medicaid
4 Sedentary		10 pts		<input type="checkbox"/> Other
Wheelchair	<input type="checkbox"/> 1 Yes		Financial Difficulty	<input type="checkbox"/> 1 Yes
	<input type="checkbox"/> 2 No		5 pts	<input type="checkbox"/> 2 No
Vision	<input type="checkbox"/>		Estimated Monthly Income	<input type="text"/>
1 Adequate		3 pts	Estimated Yearly Income	<input type="text"/>
2 Partial		5 pts	Adjusted Income	<input type="text"/>
3 Blind			Wants to	<input type="checkbox"/> Work
Glasses	<input type="checkbox"/> 1 Has wears		1 Yes	<input type="checkbox"/> Volunteer
	<input type="checkbox"/> 2 Has does not wear		2 No	
	<input type="checkbox"/> 3 Has no glasses		Total "At Risk" Points	
Hearing	<input type="checkbox"/>			
1 Adequate		3 pts		
2 Partial		5 pts		
3 Deaf				
Hearing Aid	<input type="checkbox"/> 1 Has wears			
	<input type="checkbox"/> 2 Has does not wear			
	<input type="checkbox"/> 3 Has no aid			
Teeth	<input type="checkbox"/> 1 Adequate			
	<input type="checkbox"/> 2 Inadequate			

judged by an independent evaluator to be at very high risk of needing institutional care without Project Independence services.

SERVICES PROVIDED

Many of the more populated areas had some capacity to serve the new enrollees, but rural areas varied in their ability to respond, with some offering virtually no services. As a result, and with approval of the Governor's Commission on Aging, the Office of Elderly Affairs set aside about one-third of the initial funding for start-up efforts in districts that needed to, say, establish a bus route or put together a homemaker service.

Throughout the program, homemaking has been the most commonly needed service, but one for which there were relatively few sources in rural areas. Now, a number of new private and non-profit organizations have developed.

Services have been given standard definitions and are provided by local service provider agencies under contract with local Area Agencies on Aging.

EVOLUTION OF THE PROGRAM

A search for alternatives to nursing home care began to take shape in 1971 stimulated by ideas gained by Oregon's delegates to the White House Conference on Aging that year and by the relatively new Older Americans Act. Elderly activists from the Governor's Commission on Aging and the Oregon State Council of Senior Advocates prodded State legislators, administrators, and local officials to accelerate action to help elderly persons remain in their own homes.

In his election in 1975, Governor Bob Straub, and Senate President Jason Boe, joined the advocates to develop and implement a two year program of "supportive social services for persons aged 60 or older." That launched Project Independence.

Oregon's Project Independence was begun in 1975 because State officials and legislators became aware that:

- There were very few options available to elderly persons who had difficulty managing at home other than entering nursing homes.
- Public dollars were more readily available for nursing home care of low income persons than for alternative care. As a result, at least 15 percent of Oregon's nursing home population did not need medical care on the day of

admission.

- Many low income persons become dependent on public funds (welfare) when admitted to a nursing home -- or soon after.
- Most elderly persons and particularly those who really don't need nursing home care prefer to remain in their own homes.

-- Services provided at home can often be effective -- and less expensive -- than nursing home costs.

Too often, when a decision is made for an elderly person to leave home for institutional care, it is only because a woman's stiffened shoulder joints make it hard for her to fasten her dress in back and reach her cupboard or an otherwise healthy man experiences sudden and deep feelings of loneliness and despair upon being widowed.

A total of \$929,000 was appropriated for the Department of Human Resources for program operations from July 1975 through June 1977. The department sought recommendations for program objectives from the Governor's Commission on Aging and delegated administrative responsibility to the Office of Elderly Affairs.

Project Independence monies are allocated to all areas of the State and managed at the local level by Area Agencies on Aging. The local AAAs write contracts with local provider agencies.

TYPICAL ENROLLEES

Of the current enrollees, about 70 percent are women. 58 percent live alone, 36 percent are widowed and 80 percent are 75 or older. Some typical Project Independence enrollees are:

- A partially paralyzed man, who is hard of hearing, has few teeth and lives alone in an isolated area. He can drive, but seldom sees his neighbors. "I've been in a nursing home," he says, "but you get so you hate it and everyone around you." Project Independence keeps him independent with personal care from a homemaker service and occasional help in cleaning his home.
- An elderly widow, who is nearly blind and must walk with a cane, has no family. She lives in a small, neat, second-floor apartment and can do her own cooking and housework. Project Independence arranged for a volunteer from the senior center to telephone her regularly and to provide transportation to help with shopping.

- A woman of nearly 90, somewhat confused and with only peripheral vision, lives in an apartment whose cluttered state distressed her landlord. Now she gets help with shopping and goes to the local nutrition site for lunch. Under project funding a housekeeper helps clean her apartment and a protective service worker visits regularly to assist in financial and legal matters, and other needs.

DAY CARE

When Project Independence started in 1975, Oregon had no day care programs for the elderly, so two small day care demonstration programs were funded under the project.

Both day care centers are in the Portland area and feature a pleasant home-like atmosphere. Some patients have been recently discharged from hospitals and are referred for short-term therapy; others are isolated, lonely, frail persons who need to socialize and be assured of at least one nutritious meal per day.

Services emphasize social activities, crafts and games, and the hot noon meal, but include some nursing services as well as occupational and physical therapy. The centers are open weekdays from 7:30 a.m. to 5:30 p.m.

Transportation to and from the centers is arranged through a variety of local agencies and volunteer services for the elderly. Generally, the participants fall into one of three categories:

- Those who live with younger families that for one reason or another can no longer take care of them 24 hours a day. (Perhaps the wife has taken a job outside the home.)
- Those living alone who have been isolated so long they need stimulation from an outside source.
- Those discharged from hospitals whom physicians refer for occupational or physical therapy. (One such woman who had a stroke that affected her right side had difficulty in preparing meals. At a day care center, she learned to cook with her left hand.)

The two centers have aroused considerable interest and inspired some efforts Statewide toward establishing further day care services. Area Agencies on Aging in several parts of the State are currently considering day care in their planning for 1980-81.

ADMINISTRATIVE COSTS LOW

When Project Independence began, the legislature required that all funds be spent on services rather than administrative costs for the first 18 months. Thus, the program was "piggy-backed" on the existing management structure of the Area Agencies on Aging throughout the State, which are largely Federally supported. Governor Straub credits these agencies for their concentrated efforts to establish Project Independence services during the initial two years of the project. The program's early successes must be attributed in large part to the continuous cooperation of the Area Agency staffs.

At this time, Project Independence enrollees and fiscal reports are submitted separately from records which report services rendered under the Older Americans Act. The Area Agencies are responsible for management of contracts written with local providers of Project Independence services.

Project Independence receives no Federal dollars. (Oregon long since reached its Federal ceiling for social services under Title XX of the Social Security Act.)

Other factors in keeping costs low are: (1) extensive use of employees paid by the Federal Comprehensive Employment and Training Act to provide services, such as homemaking; and (2) some 40 percent of services are relatively low in cost or performed by volunteers, such as telephone assurance, transportation and friendly visiting.

In 1977, Governor Straub recommended an increase in biennial funding from \$929,000 to \$1.7 million. A coalition of senior advocates asked the legislature to raise it further to \$2.7 million, and the legislature responded favorably.

For the two-year period (July 1977 - June 1979), the legislature approved the department's recommendation to allocate five percent of the total funds for administrative costs. Two percent are assigned to the State-level Office of Elderly Affairs, with three percent to the Area Agencies on Aging.

Governor Victor Atiyeh has recommended an increase to the 1979 legislature which would bring the Project to \$3.6 million for the biennium, and the current coalition of senior organizations (United Seniors '79) is requesting increases that would total \$5.3 million. Legislative action is pending.

IMPROVING THE PROGRAM

The program has received national attention through a seven-minute segment that appeared on an NBC network news program in June 1977. The camera crew (with permission of enrollees) went into enrollees' homes to illustrate how program services helped them remain independent. This stimulated inquiries from all parts of the country and even from England.

Now, very few parts of the State offer the full range of alternative services necessary to give the frail elderly all options that are needed for individual appropriate care. The Office of Elderly Affairs and Area Agencies on Aging are continuing an effort to plan and develop those additional options.

Governor Atiyeh, the Commission on Aging and the Oregon Legislature are pleased with the results of Project Independence.

Nearly two-thirds of Project Independence clients are able to postpone or avoid placement in a nursing home.

Since the number of "older old" people, age 75 and over, is the fastest growing age group in Oregon (and elsewhere), and it includes the highest percentages of frail persons, a program, such as Project Independence, which targets services to that frail population, can and does claim cost-effective results.

SUMMARY OF NURSING HOME WITHOUT WALLS LAW
(CHAPTER 895, NEW YORK STATE LAWS OF 1977)

Chapter 895 of the Laws of 1977, "The Nursing Home Without Walls" Law, which became effective April 1, 1978, authorizes the establishment of long term home health care programs as an alternative to institutional care. This law, which was three years in development, was conceived as a means of providing long term care tailored to meet the needs of the patient rather than the usual method of the patient meeting the requirements of a program.

In addition, the occupancy rate in New York's nursing homes exceeds 96%, and in some areas there are no nursing home beds for patients who could be discharged from much more costly acute care beds.

In 1976 long term care in New York State took one-third of the Medicaid budget while in 1967 the same care consumed 12% of the Medicaid budget. As a result of the increasing elderly population it is expected that the portion of the health care dollar devoted to long term care will continue to rise.

Rather than meet the increasing demand for long term care through construction of more nursing homes, thus paying for bricks and mortar, available funds should be more appropriately used to provide patient care. Social as well as fiscal reasons dictate that we develop alternative, non-institutional methods of providing long term care. Although a nursing home is now authorized to care for a certain number of patients within a facility, there is no reason that same nursing home could not also provide the same level of care to people in their own homes. The nursing home would manage the patient's case but the patient would not physically reside in the facility.

The "Nursing Home Without Walls" program has three key elements: 1) the selection of the provider; 2) the financing mechanism; and 3) the selection and management of the patient.

SELECTION OF PROVIDERS

Long term home health care may be provided by certified home health agencies and by public or voluntary non-profit residential health care facilities and hospitals which have received the authorization of the State Health Commissioner. The Commissioner's determination is made on applications submitted by potential providers after considering the recommendations of the appropriate

Health Systems Agency and the State Hospital Review and planning Council. In approving an application, the number of patients for which a program may provide care must be specified.

A detailed application is first submitted to the Commissioner, who forwards it to the appropriate HSA and the State Council. The application must include a description of the need for the proposed program, the geographical area to be covered, the estimated number of patients, and projected common diagnoses of the caseload. Policies for admission and discharge of patients from the program must also be described. Additional information required includes the relationship of the proposed program to the organizational structure of the parent facility; arrangements for coordination of services with other providers; arrangements to ensure the availability of 24 hours per day, 7 days per week professional assistance; arrangements for provision of emergency care; availability of additional community support; anticipated staffing requirements; mechanisms to assure the provision of quality care; long range operational plans; available financial resources and the general financial stability of the applicant; and the adequacy of procedures for patient identification and entry into the program.

A provider of "nursing home without walls" care must make available, either directly or through contract arrangements, the following services: nursing; home health aides; physical, occupational, respiratory, and speech therapy; audiology; medical social work; nutritional services; personal care, homemaker and housekeeper services; and medical supplies, equipment and appliances. Nursing, home health aide, personal care, and homemaker services must be available 24 hours per day, 7 days per week.

The "nursing home without walls" program is to be a distinct part of an agency or facility with a full time director. Each provider must have a physician advisory committee with the responsibility of developing and approving standard medical regimens and policies. A professional advisory committee, comprised of the agency administrator, a practicing physician, a representative of the community, a consumer representative, and a representative of the nursing and other professional staffs, is to be responsible for reviewing policies on the delivery of care; developing agreements with other facilities in the area for the acceptance of patients referred for long term home health care; reviewing the quality of services; and advising the program on any needed or unneeded services.

FINANCING MECHANISM

Payment for "nursing home without walls" care will be made under the Medicaid program. A county social services department will develop an individualized monthly budget to pay for the services deemed necessary for each patient. The monthly budget is limited to 75% of the average monthly SNF or HRF rate, as appropriate for the level of care required by the patient, in the county in which he resides. If the patient does not use the total amount available to him, the balance accrues to him as a "paper credit" and can be used at a later date to provide additional care if required.

For example, if the average skilled nursing facility rate in a county is \$1,200 per month, up to \$900 per month is available for a "nursing home without walls" patient. If the patient requires health services costing \$600, the \$300 balance accrues to his account, and can be used at a later date if the patient's needs become more costly.

The State Department of Social Services, in an administrative letter to the counties, has indicated flexibility so that if a patient's costs exceed his allocation for a temporary period, the patient may remain in the program. The county department of social services will review the budget monthly.

Currently, Medicaid reimbursement for home health care is available only for nursing and home health aide services, occupational, speech and physical therapy, and medical supplies and equipment. The U.S. Department of Health, Education and Welfare has approved a demonstration project which permits the use of Medicaid funds to pay for a broader range of services under the "nursing home without walls" program. These additional services include respiratory therapy; psychological counseling; nutrition services; structural improvements; respite care; and home maintenance services. Often the availability of these additional services is key in preventing premature institutionalization of the elderly.

SELECTION AND MANAGEMENT OF PATIENTS

Medicaid eligible persons who have been assessed as needing care normally provided in either a skilled nursing facility or a health related facility are eligible to receive "nursing home without walls" care. This care may be provided in the person's own home or in the home of a responsible relative or other responsible adult.

To be accepted into the "nursing home without walls" program the following steps will be taken:

1. The client, or someone on his behalf, indicates that he believes SNF or HRF care is needed.
2. A medical assessment in either the person's home or in a facility in which the person is a patient must be completed.
3. If the client is assessed as needing either skilled nursing or health related care, and a long term home health care program exists in the county in which he resides, the local social services department must inform him of its availability.
4. The patient, or his representative, must indicate whether he is interested in receiving care at home.
5. If the patient desires "nursing home without walls" care, and if his physician has indicated that home care can appropriately meet his needs, a comprehensive home assessment will be performed. The appropriateness of the home environment in relation to care the patient requires would be determined as well as the feasibility of delivering that care at home. This assessment forms the basis for a plan of care tailor made to the individual patient's needs. The assessment team includes the patient's physician, the provider of "nursing home without walls" care, and the county social services department. If the patient is referred from a hospital or nursing home, the facility's discharge planner also participates. If the physician determines that the patient's health and safety needs cannot be met at home, the patient would be deemed inappropriate for "nursing home without walls" care.
6. A coordinated plan of care is developed through the cooperation of the assessment team.
7. The physician must give final approval to the plan of care, specifying kinds and amount of services required. The plan is then submitted to the county social services department for a budget review to determine whether the total cost of the program is less than 75% of the monthly average SNF or HRF rate, as appropriate.
8. The provision of care begins.

Both the long term home health care provider and the local department of social services will play important roles in managing each case. The local social services department will provide case management services, including determining Medicaid eligibility; participating in the comprehensive assessment; preparing the monthly budget, including maintenance of the "paper credit"; arranging for the delivery of supportive services required in the plan of care; and arranging for the continuation of services, provision of additional services, or provision of alternative services if necessary.

The long term home health care provider will have responsibility for cooperating with the assessment, particularly from a medical, nursing and rehabilitative focus; development of the plan of care; implementation and evaluation of the plan of health care; assuring that medical orders are followed; and supervision of health services.

The comprehensive assessment will be repeated at 4-month intervals, or more often if the patient's needs require. The reassessment is to include a total reevaluation of the current medical, social, environmental and rehabilitative needs of the patient.

The same law also establishes a State Council on Home Care Services to advise the governor and the Commissioners of those departments involved with the welfare of the elderly as well as the social and physical needs of our citizens. This Council, which will meet at least quarterly, will concern itself with the review and coordination of efforts regarding the development of home care services and is to make appropriate recommendations to the governor and the legislature. The governor may also prescribe other functions for the 25 member Council which serves on a voluntary basis. Members include commissioners of relevant State departments, the chairman of the State Hospital Review and Planning Council, plus 17 members who are deliverers of home care service and representatives of the public, appointed by the governor with the consent of the Senate. Each health systems area must be represented.

The Commissioner of Health is authorized to inspect certified home health agencies and providers of long term home health care programs with respect to equipment, personnel, standards of service and care, accounts and financial resources. In addition, any organization which provides or makes available home care services must annually submit a description of its operation to the Commissioner. This will be public information so that all citizens may be aware of available services.

At the end of 1978, 2 hospitals, 2 nursing homes and 9 certified home health agencies had been authorized to provide "nursing home without walls" care. The Department of Health has received applications for authorization from an additional 13 agencies and facilities.

The Department of Social Services has estimated that in its first year of operation, the "nursing home without walls" program would result in savings of \$11.8 million over what would have to be spent to care for the same patients in residential health care facilities. These estimates are based on a projection of 2,000 "nursing home without walls" patients by March 31, 1979.

The Departments of Health and Social Services, as well as the appropriate legislative committees, will carefully monitor the implementation of this law to assure that appropriate quality care is delivered through this new program which is the first of its kind in the nation.

IV MEDICAID MANAGEMENT AND ADMINISTRATION

Don Nicholson
Director, Office of
Program Integrity
HCFA

CONTROLLING MEDICAID
FRAUD & ABUSE

The Office of Program Integrity at HEW has the same concern as State legislators. You want to be sure that the taxpayers in your State are getting the greatest value for their health tax dollar. You want to be certain that those dollars are tightly controlled and paid only as appropriate for medical services truly required and actually rendered. As a part of your overall responsibility, you want to be especially certain that your State's Medicaid program is being managed and operated in a way to keep fraud and abuse to a minimum.

Since our concerns and objectives are mutual, I am happy to share with you some of my thoughts on Medicaid fraud and abuse, and attempts to control it.

By creating the Office of Program Integrity within the Health Care Financing Administration, the Department recognized Medicare and Medicaid as sister programs that could benefit from common approaches in management and administration. Our office has responsibility in both Medicare and Medicaid. We combined the former Medicaid Fraud and Abuse staff with the former Medicare Program Review staff. Our combined forces total approximately 350 people, with about 250 of those in the Regions. The Central Office provides support to the Regions with training legislative research and development activities. We also have an oversight role to insure that the regions conform to established policies and are consistent in their program responsibilities.

The Regional Offices have two major functions which we have defined as management review and case development.

The case development staffs are responsible for handling specific cases of reported or detected fraud or abuse. In conducting their reviews and investigations, case development staff work closely with another Regional staff, the Office of Investigation, which is under the direction of the HEW Inspector General, Tom Morris. The OI staffs are responsible for all criminal investigations and those cases involving criminal fraud have OI guidance.

The management review staffs in the Regional offices oversee Medicaid State agencies and Medicare contractors to ensure that they fulfill responsibilities regarding a total system of fraud and abuse control. In addition, they are responsible for coordination,

training and technical assistance that is critical to a successful program integrity effort. In performing these functions, the regional management review staffs relate closely to the Medicare and Medicaid program agencies.

Although Medicare has had fraud and abuse controls dating back to 1968, the Medicaid program at the Federal level established the Division of Fraud and Abuse Control in 1976.

What follows is an indication of our level of activity so far:

General

- State abuse reviews - 7 States
- State assessments - 47 States
- Model State legislation
- Prosecutors handbook

Medicaid

- Investigators guide
- Institutional review guide - nursing homes and hospitals
- Review guide for physicians, pharmacies, laboratories
- Project Integrity
- 30,000 cases of fraud and abuse investigated
- Nearly \$35 million in overpayments recovered

Medicare

- 350 cases referred for prosecution
- 250 prosecutions
- 50 cases pending trial
- Annual reviews of Medicare contractors

Now, where do we plan to go? What are our priorities and, specifically, how can our priorities be dovetailed to yours to ensure that we are working cooperatively?

The most important thing I need to mention is HR-3. Ultimate passage of this legislation now appears to be a certainty. (HR-3 was signed into law on October 25, 1977, becoming PL 95-142. Ed.) In my opinion, the most important provision of that legislation regarding Medicaid fraud and abuse control is the one providing 90 percent Federal match of States' Medicaid investigation and prosecution. The conference report on this provision and all of HR-3 was printed in the Congressional Record and we have been drafting the regulations necessary for implementation. Briefly the provision allows the higher matching funds for program units exclusively devoted to Medicaid fraud investigations and prosecution. The Secretary will have to measure the State's organizational structure against established standards to determine eligibility for the funds that will be awarded for three years. The unit must be separate from the State agency administering the Medicaid program and have Statewide prosecutorial authority.

This provision will encourage the States to focus specifically on problems of Medicaid fraud and to provide expanded resources for doing so. We are working now to establish the standards that States will have to meet to be eligible for the additional monies.

There are many more provisions of HR-3 designed to strengthen Medicare/Medicaid fraud and abuse efforts which you will be hearing about in greater detail. They include:

- Increasing the penalty for Medicare fraud,
- Terminating any provider convicted of Medicare or Medicaid fraud, and
- Requiring disclosures of more than 5 percent ownership in nursing homes.

Another priority we have is to improve our capability and that of the States in the area of institutional fraud and abuse detection and investigation.

To develop effective post payment review systems, States will have to establish parameters that will allow for effective identification of providers with "out-of-line" billing practices. An eventual combining of Medicare and Medicaid data bases would permit a complete display of a provider's billing pattern under both programs. Efforts to provide publicity to increase public awareness and provider appreciation of the problems of fraud and abuse are also essential.

There must be an improvement in the conduct of the investigations. Investigator training should use expertise developed during

years of Medicare experience. Justice Department and State and local prosecutors should be involved in training the investigators.

In addition, States will have to improve their capacity to sanction providers who abuse the program, but who are not guilty of fraud. Involving Professional Standards Review Organizations (PSROs) and sending warning letters should be a first step, with recovery of funds and suspension used when necessary.

Finally, States will have to use their data better, looking for trends of patterns of abuse or over-utilization by service type. Medicaid Management Information Systems will be increasingly important in control of fraud and abuse.

Let me summarize by saying that I believe there are basically seven elements necessary to a good fraud and abuse control system.

1. Prepayment Central System

The claim that shouldn't be paid should be detected before it ever runs through the system.

2. Post Payment Central

States must be able to examine after the fact what providers have received as payment for services rendered. Furthermore, some basis should be established to compare specific providers against a norm.

3. A Good Beneficiary Feedback System

When a recipient feels there is a problem with services paid by Medicaid, the system should be able to respond.

4. Analysis of Complaints and Profiles

Whatever the feedback from recipient or profile, someone has to have authority to decide whether there is a legitimate problem that deserves review and investigation.

5. Investigative Capacity

Someone must be assigned the leg work for a Medicaid records review, a beneficiary interview, a cost report analysis, or whatever the situation requires.

6. Process for Final Adjudication

Regardless of the quality of the detection or investigation system, unless there are procedures to fit the penalty to the crime little has been obtained.

7. Statutory Base for Prosecution

This is related closely to the final adjudication process, but deserves special mention because the State law must recognize that taxpayer dollars fraudulently claimed deserve a courtroom remedy.

If all seven of these elements are working in your State, I expect you have a pretty good system of fraud and abuse control. In terms of the level of total resources contributed to this activity, State officials must consider the costs and the benefits and should demand indicators of performance. What was the rate of convictions? How did identified providers change their pattern of practice?

At the Federal level, we're going to be interested in the same things -- especially if we fund at 90 percent.

Victor Kugajevsky
Assistant Director
Office of Policy & Program
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MANAGING THE MEDICAID PROGRAM

A good starting point for addressing the issue of how to improve Medicaid management is to define the principal purpose or mission of Medicaid. To me, that translates into a simple statement: the purpose of Medicaid is to provide quality health care to the poor citizens of this country at an affordable price. Using that as a reference point, we can take a quick look at what Medicaid has done because, while it is a problem-ridden program, it is also a program that can point to some real achievements.

Medicaid today covers about 23 million American citizens with a relatively comprehensive set of health care benefits, free of cost. It involves about half of the 17,000 convalescent facilities in the country, half of the 7,000 hospitals in the country, about 70 percent of the pharmacies, and about 40 percent of the 250,000 practicing physicians.

Thus, Medicaid means a lot to its beneficiaries and to the provider community. Next year HEW estimates that the program will cost about \$20 billion in Federal and State funds. That breaks down to about \$60 million a day paid out through the Medicaid program. Quite simply, it is a huge and vital program. In perspective, Medicaid is as big as the two biggest corporations in our country, General Motors and ITT.

What are some of the major achievements of the Medicaid program? While we cannot attribute these results entirely to it, Medicaid has certainly played a key role in bringing them about. Several indicators of the positive results are the following: infant mortality rates among the poor have dropped about 50 percent over the last 5 to 10 years, from about 75 cases per 1,000 to about 35 today. Physician visits, another indicator, at least of health access, which used to be way below for the poor compared with the middle class, are up about 40 percent, from about 2.5 per year per poor person several years back to about 3.7 per year today. In fact 3.7 is a little bit above what the average number of visits for the middle class individual is today. This is even raising some concerns about whether there may be too many physician visits among the poor today.

Alongside the positive benefits of the program, there clearly are some very severe problems. The first is obviously the very

rapid growth in the program and its expenditures. Medicaid is costing about \$18 billion today, and is expected to cost about \$20 billion next year, and \$25 billion by 1982. That represents a rate of increase of more than a billion dollars per year! Next to that escalating growth curve, the second problem is both the perception and the reality of extensive waste, fraud, and abuse. HEW calculated that for last year, FY 1977, when the program was around \$16 billion in total expenditures, the amount of wastage totalled about \$2 billion per year, over 12 percent of the program. Included in that \$2 billion are three sources of wasted, lost, and inappropriately spent Medicaid dollars: first, payments of about \$1.2 billion for ineligible; second, \$600 million lost through unrecovered third party liability, where Medicaid recipients have other health insurance that by law is required to pay their medical expenses before Medicaid pays anything; and last, \$200 million in claims processing errors where Medicaid is paying a service that is not authorized in a particular State, or to a provider that is not certified, or at a fee level above the permissible fee schedule in the State. Two billion dollars is a pretty hefty loss factor in a program of this size. And it clearly is due to the third major problem -- the lack of adequate management controls in the program. It's always astonishing to me, to see a program of this size, as big as General Motors or ITT, and to compare the kinds of information management and administrative control systems that these corporations have with what we have in Medicaid; it's like night and day. The Medicaid Management Information System (MMIS) is one major step to bringing Medicaid into the world of 20th century management. The last problem is public dissatisfaction. Given all of the previous three problems, great expense, waste -- the actuality and perception of it -- and ineffective management, it's no surprise that extensive dissatisfactions exists among the taxpaying public and also among the beneficiaries. So given this background, what can be done about addressing some of these problems?

The first thing that needs to be recognized is that the program is managed in a dual partnership kind of mode with the Federal government being one partner and the States in their various capacities -- both executive branches and legislative branches -- the other partner in the program.

My thoughts on what the Federal government's role in the management of the program ought to be are as follows: First, the Federal government can make a serious and concerted effort, and this is underway, to try to simplify the rules under which the Medicaid program is run and is required to be run by States. Second, the Federal government can encourage management improvements like the MMIS and the revised Medicaid Quality Control (MQC) program. Third, they can set performance standards against which we can measure the adequacy of Medicaid program performance,

and HEW has a significant effort underway on that front. Fourth, they can enforce accountability. Again we have not, from the Federal perspective, held State Medicaid programs to any sort of accountability test partly because of the absence of performance standards. But I think we are moving toward that objective. And fifth and last, they can stay out of the States' hair because the Federal government does not manage the program on a day-to-day basis. State agencies are responsible for day-to-day operations and I think we can do them a great service by recognizing that they are capable of managing the program. They are closer and more aware of what the problems are and how to deal with them. We can help them but we should not get in their way when they choose a particular approach -- which may not be the Federal approach -- to getting agreed upon results.

What then can State officials do to manage the program and to make necessary improvements? There are three general things that ought to be considered. First, at the State level there needs to be developed a consensus between the executive and the legislative branch about what the goals and objectives of the Medicaid program should be in that State. If nothing else, some common understanding of what the Medicaid program should be trying to achieve in that State should be obtained. That is difficult to do but it is an area that is worth spending some effort on. Second, the State should introduce modern management techniques, of which MMIS and MQC are the most significant and readily available, into the administration of the program. And third, State officials can encourage learning from other States, both at the executive branch and at the legislative branch. States have been very creative on an individual basis in coming up with unique and very effective ways of dealing with various aspects of Medicaid program administration.

What can State legislators do specifically to help improve the management of Medicaid? State legislators generally play a dual role vis-a-vis the Medicaid program in their States. Using an analogy from private industry, the State legislature carries out the dual role of being a board of directors to the Medicaid program and a banker to that program. In its board of director's role, the State legislature sets the broad policies under which the Medicaid program will operate in that State, and also defines the scope of the program, generally by establishing who is eligible for what services. In its second capacity, the State legislature provides the funds to operate the program. In this role, the State legislature is making an investment decision about how to use public funds. Using public funds for the Medicaid program obviously precludes their use for other purposes. There is a cost opportunity involved; therefore, State legislatures should have available to them information that is normally required to make a good investment decision.

In broad terms, then, a State legislature's role can be described as the Medicaid program's banker and board of directors. But also there are more specific tasks that State legislators can focus on. To begin with, legislators should really take an attitude of hard-nosed oversight with the program. They should insist on performance accountability of their State Medicaid program and they should provide support for management improvement in the program. That support should take several forms. The first is to help resolve the numerous policy problems that make effective management difficult. There are policies presently in existence that simply preclude or are a deterrent to good efficient management. Moreover, State legislators ought to be receptive to changing those policies when they are made aware of the problems. Second, they must be willing to provide the resources needed for better management. A lot of State Medicaid programs are under-managed because they simply do not have the resources -- both dollars and people -- required to do a good job. And a third task that can be done in terms of supporting management improvement lies in addressing the public image and perception of the program. Often-times, pointing out in a glaring fashion the deficiencies of the program can interfere with making improvements. Some care and more judicious use of washing all the dirty linen in the mass media need to be taken. These are the kinds of emphases that I think a State legislature could take in improving the Medicaid program.

Let me get a little bit more specific on what I think might be an additional useful tool besides the Medicaid Management Information System and the revised Medicaid Quality Control system that would help State legislators carry out their responsibilities. One of the things I mentioned is that in appropriating dollars for the Medicaid program a State legislature is making an investment decision on how to use public funds. In order to do that wisely, basic information is needed on the Medicaid program -- information which is not available. One way to make it available is to require each State Medicaid program to provide to the legislature an annual report on the status of the Medicaid program. Not a 100 page document, or even a 50 page document. Rather the kind of document that private corporations prepare for their stockholders, for their investment advisers, and for their bankers, that informs them as to what is happening in that particular enterprise. Such an annual report should focus on three areas of a State's Medicaid program. First there should be information on the status of the program: what is its total cost, how much of that total cost goes toward beneficiary payments, how much toward administrative costs, and what are the changes and trends over the years. The next part of the status area in this annual report is who are the beneficiaries, how many are there, how many elderly, how many AFDC recipients, and again the changes over the years. The second area of this annual report is information on the administrative efficiency of the program.

The following are examples of indicators of administrative efficiency. What is the ratio of administrative costs to program dollars? How much is being spent on administering the program versus how much is being paid out for medical costs? Another kind of indicator - what does it cost to process a claim? Presently, Michigan has the lowest claims processing costs in the country. It might be interesting to see where your individual State is on that kind of measure and perhaps if it is on the high side, question why.

Another is the claim turnaround time; how much time on the average does it take to pay claims? That is very key, obviously, to positive provider relations. The longer one takes to pay claims, the worse those relations. A fourth possible area, in terms of administrative efficiency, is staff turnover, which, particularly in the public welfare programs, is a major source of significant problems. With a high staff turnover, it is difficult to build the kind of staff continuity and quality that an enterprise the size of Medicaid requires to be effectively managed.

The third area that needs to be addressed in this annual report is program performance. How well has the program performed? One suggested indicator of program performance is the level of erroneous payments in the Medicaid program. Every State is now operating the new Medicaid Quality Control system that provides the following routine month-to-month information: the percent of total payments that are made correctly, the percent made incorrectly, the amount paid for ineligible, the amount lost through unrecovered third party liability, and the amount lost through claims processing errors. (A more detailed description of the new Medicaid Quality Control (MQC) System is contained in the Appendix.) The second indicator in this program performance area is the ratio of recoveries to total erroneous payments.

The last area that ought to be included in the program performance portion of the report is something that gets at the question of equity for the beneficiary of Medicaid: how much time does it take on the average to process a Medicaid application? In some States, it takes 5 to 10 days and in others, it takes months. How long does an applicant who applies for Medicaid have to wait before a decision is made as to whether he or she qualifies? Another equity indicator of how well the beneficiary of this program is being treated - what is the ratio of fair hearing requests versus total applications? If a lot of applicants are being Improperly turned away from the Medicaid program for which they qualify, this will show up in fair hearings requests. Monitoring that kind of indicator over time provides a good idea of what is happening. Another part of the quality control system that can be used to get at the question of beneficiary equity is the negative case action component which measures the level of errors

where the State has improperly terminated or denied an applicant. Again, a focus on this will provide a good indication of equity, or how many people are improperly denied access to Medicaid when they actually qualify for it.

These are some of the kinds of information that should be organized in an annual report that covers these three areas - what is the status of the program, what is its administrative efficiency, and what is its program performance. Through such a report, useful information would be provided to State legislators by which they can make sound decisions on the adequacy of the administration of the program, the effectiveness of management, and the need for further investment in the program in order to improve either the management or the benefits side. Such a document will also begin to provide the basis for dispelling some of the erroneous perceptions about how well or how poorly this program is managed. Having such a report on a routine basis can dispel any false myths about the program and also point out any real problems. As it is for private companies, an annual report could be a valuable addition to the tools needed to improve the management of Medicaid.

Dr. Paul Allen
Deputy Director
Michigan Department of
Social Services

IMPROVING MEDICAID MANAGEMENT:
THE MICHIGAN EXPERIENCE

The Michigan Department of Social Services is responsible for the administration of a number of programs providing services to the needy population of Michigan which fall into three broad categories: financial and medical assistance, and social services. Programmatic and administrative responsibility for these programs is vested in a single agency since all such programs provide services to essentially the same population of eligible individuals; e.g., those eligible for Aid to Families with Dependent Children are also eligible for food stamps, medical assistance and most services programs. As such, when Title XIX of the Social Security Act, which established the medical assistance program, became effective in October, 1966, the Department of Social Services was designated the agency responsible for its management.

Under the provisions of Title XIX, the various States were given the opportunity to establish, with Federal guidelines, programs providing for the medical care of indigent populations. The Title also provided for Federal financial participation in the costs of providing services and administering the program.

Michigan's was among the first medical assistance programs established. The program, which replaced a number of less comprehensive programs including Kerr-Mills or medical assistance to the aged, provided coverage to an expanded group of eligible individuals. From a rather modest beginning, providing benefits worth about \$67 million to about 176,000 individuals in 1967 (the first full year of operation), the program has grown to the point at which it now pays nearly \$800 million annually to provide benefits to about 860,000 persons.

As the program was originally organized in Michigan, a small administrative and policy staff was maintained by the Department of Social Services with fiscal intermediary functions, i.e., claims processing and payments, and associated accounting and reporting functions performed by Michigan Blue Cross and Blue Shield under contract to the Department. Eligibility determination was, and continues to be, a function of the Department's local offices.

As was the case in many other States, this original program was developed in a very short time and, as a consequence, it was not possible to thoroughly plan detailed systems and procedures.

As a result, the original system did not provide adequate information with which to manage and control the program. As such, in late 1969, the Michigan Department of Social Services, with the support and cooperation of the executive office and the legislature, initiated a project to design and implement an improved medical assistance management program. Analysis of the existing system, definition and documentation of requirements for an improved system, and the process of selecting a fiscal intermediary to perform claims processing functions were undertaken during 1970. During early 1971, proposals solicited from prospective fiscal agents were evaluated and compared for selection. These evaluations, in conjunction with changes in the circumstances under which requests for proposals were submitted and an indication that substantial savings in administrative costs would be realized, demonstrated that it was both feasible and cost effective to assign the fiscal agent function to the State of Michigan.

Accordingly, the decision that the State would act as its own fiscal agent was made, and the development of a State Medicaid system, under the direction of the newly created Bureau of Medical Assistance in the Michigan Department of Social Services, was begun. Implementation of the program and concurrent phase-out of Michigan Blue Cross and Blue Shield, which had been acting as fiscal agent from the program's inception, began in April, 1972 and was completed with full assumption of responsibility by the State, and termination of Blue Cross and Blue Shield in March, 1973.

Medical costs in Medicaid have grown faster than other costs in social services and perhaps in any other area of government. In my opinion, they have grown in Michigan for three major reasons: (1) the general inflationary rise in health care costs; (2) the rise in case load -- a manifestation of the energy problem that affected the auto industry; and (3) the rise in utilization. In regard to the utilization increase, there is an obvious propensity to increase use of free services. There is a national trend to require third party insurance programs to pay the bills, a practice that increases utilization. This is particularly true in many States where there is no cap on what you get with the Medicaid card.

One of the major problems is that the marketplace for medical support is different from the free, capitalistic marketplace. First, the availability of customers for the Medicaid program is not dependent on the amount of money in the customers' pockets. Then, the pricing mechanism is altogether different. The philosophy of financing is also different. Federal control, States' standards and criteria, and disparity of standards among the States all are involved in the process.

Michigan will spend five percent of all the Medicaid dollars in the United States in FY 1977. We will spend more than \$800 million this year -- half State and half Federal funds. Other States with other philosophies are spending less, but this does not necessarily mean lower cost per person in terms of return for money invested.

Michigan has more liberal standards in its benefit package and fee schedules. These have to be examined in relation to cost containment by the administrator while providing needed services. Within this context, one must examine where the money is being spent. The breakdown is: 36 percent for hospitals, 33 percent for long term care, 16 percent for physicians and 8 percent for pharmacy and labs. A total of 93 percent of all Medicaid moneys is being spent for these services.

Again, to contain costs you have to examine where you're spending your money. In Michigan, we have a management information system second to none. We know where the problems are, but we can't control the marketplace. Some 900,000 people in the State -- ten percent of the population -- are on Medicaid. We represent approximately 15 to 20 percent of the marketplace because we spend considerable sums in nursing homes that the private sector doesn't.

Therefore, if 15 percent of the marketplace is going to influence the other 85 percent, they better communicate with those involved in that 85 percent. That would include industry, the Blues, commercial insurance firms -- every group paying the rest of those bills. In Michigan, we have discussed several ideas that had to be discarded because we can't control the marketplace in a cost-oriented environment where, usually, there is no financial incentive to minimize costs.

We must reorient our thinking toward establishing realistic limits in the marketplace in terms of hospital costs, co-payment mechanisms, fee schedules and investigations of fraud and abuse. The latter is a small aspect of the program, because we do not spend moneys in great quantity in those areas where fraud and abuse is most predominant, such as labs and pharmacies.

The following material describes various administrative and management aspects of the Michigan Medicaid program which we feel will have a positive impact on controlling costs.

ADMINISTRATION

The mission of the Department of Social Services is to meet the financial, social and health needs of those persons whose requirements are beyond their individual abilities to provide. The Department advocates, develops and administers appropriate programs

in a manner consistent with individual dignity and the public interest. To accomplish this, the Department is organized into three major administrations; field services, Departmental Services and Citizens Services. Field Services, which includes the Department's network of local offices and Departmental Services, provides support for the programs for which the Department is responsible. Citizens Services Administration is vested with programmatic responsibility for the Department's major programs and is subdivided into three bureaus. The Bureau of Assistance Payments administers financial assistance programs such as Aid to Families with Dependent Children (AFDC), food stamps, and General Assistance (GA). The Bureau of Social Services includes services programs such as protective services, foster care and day care. The Bureau of Medical Assistance is responsible for management of the State's Medicaid program.

With respect to the medical assistance program, the Social Security Act requires that in each State opting for a medical assistance program under Title XIX a single agency shall be named, with ultimate authority and responsibility for administration and operation of that State's Medicaid program. Since the population eligible for Medicaid benefits includes most of those individuals eligible for other programs administered by the Department, in Michigan the Department of Social Services was designated that single State agency.

Administration of the medical assistance program includes: the eligible population; the scope of benefits; the eligible providers of services; the control of payment processes; the utilization of and the need for services. As discussed earlier, the Department of Social Services contracted with Michigan Blue Cross and Blue Shield from the program's inception in 1966 through early 1973 for claims processing and related activities. Since the completion of implementation of the Medicaid Management Information System in 1973, the Department has, through its Bureau of Medical Assistance, directly operated most aspects of the Medicaid program. A number of program subcomponents, notably Surveillance and Utilization Review, are operated and administered by the Michigan Department of Public Health under the control of the Department of Social Services through contractual arrangement. In late 1976, the Investigative and Recovery Units of the Bureau of Medical Assistance were transferred to the Office of Inspector General of the Michigan Department of Social Services.

To process the high volume of invoices received daily in a timely and cost effective manner, the Medicaid Management Information System (MMIS) incorporates a highly automated invoice processing system. Feeding this are complementary systems which enroll providers, account for monies expended, generate reports,

and provide data for utilization review functions. MMIS and the Surveillance and Utilization Review subsystem are described in detail in the following material.

An integral part of invoice processing is an optical character recognition (OCR) capability. This allows us to make optimum use of rapid data entry techniques by literally reading typed invoices onto a magnetic tape that can be quickly assimilated by the mainstream computer system, bypassing more expensive and time-consuming conventional key-entry data techniques. OCR scannable invoices were developed for each major provider type. Through close cooperation with the professional health related societies of Michigan, these invoices have been simplified and improved.

Information from invoices is electronically converted into computer language for editing and recording on magnetic tapes. These magnetic tapes are then entered daily into data processing routines which validate such items as provider eligibility, client eligibility, medical diagnosis, procedure codes, reasonableness of charges, etc. On completion of daily runs, the claims are passed on to the other routines for payment, rejection, or into a pending status for manual review. Payment is made weekly.

Those invoices which are pended for any of a variety of reasons, including faulty data, incorrect completion, etc., are identified by the computer and referred to the claims resolution section for manual review. Reviews are primarily of two kinds; medical or administrative. If the problem is primarily medical in nature, it is referred for professional resolution to the Department of Public Health. After manual review and annotation, resolved and rejected claims are entered back into the system for final processing and advice to the provider. At the present time, over 80% of all provider claims are paid in 15 days or less. Most of the remainder are paid in 30 days or less, with the balance taking longer because of their uncommon nature.

The administrative efficiency and effectiveness of this system have been amply demonstrated by its performance. The line has been held on administrative costs in a period of high inflation, rapidly expanding benefits and increasing administrative responsibilities. The program has been subjected to numerous reviews by representatives of both State and Federal agencies, has passed them all with high marks, and has been cited as a national model in many areas.

Administrative costs, as applied to the medical assistance program, encompass all costs involved in operating and managing this system. Those costs which are usually at issue, however, in discussions of administrative costs, are those attributable to

fiscal intermediary functions; that is, those involved in the actual processing and payment of bills received for services rendered under the program. Other costs are incurred by the State in addition to fiscal intermediary costs, regardless of who performs the fiscal intermediary function. Among these costs are those incurred for eligibility determination, long term care evaluation, utilization review, rate-setting, policy and planning and regulatory functions. The administrative costs per claim processed for FY 75-76 are extremely favorable and when expressed in terms of costs versus benefit payments, represent one of the best, if not the best, ratios for all health coverage plans, public and private, in the United States.

MEDICAID MANAGEMENT INFORMATION SYSTEM

Concern over rising Medicaid costs and inflation in the health care field led to the establishment of a Federal Task Force on Medicaid in 1969. That Task Force examined deficiencies of the Medicaid program and submitted final recommendations to the Secretary of the Department of Health, Education and Welfare in 1970. An outgrowth of those recommendations was the development of a Medicaid Management Information System (MMIS). MMIS, as implemented in Michigan, is intended to improve the capability of the State to administer the Medicaid program. To accomplish this objective, emphasis was placed on the development of designs for effectively processing and controlling claims and for the provision of management information essential for planning and control. MMIS consists of logically grouped individual subsystems.

MMIS specifications define six functional areas or subsystems, two of which are grouped into the invoice Processing System:

1. Client Information System (Recipient Subsystem).
2. Provider Enrollment (Provider Subsystem).
3. Invoice Processing (Claims Processing and Reference File Subsystem).
4. Surveillance and Utilization Review (Surveillance and Utilization Review Subsystem).
5. Management and Administrative Reporting (Management and Administrative Reporting Subsystem).

A brief overview of each of these subsystems is provided below:

1. Client Information System

- a. Maintains identification of all recipients eligible for Medicaid, (as well as other public assistance and services programs).
- b. Provides a mechanism for frequent and timely updates to all recipient eligibility records.
- c. Exercises control over data pertaining to recipient eligibility, including Medicare Part B buy-in processing.
- d. Provides a computer file of all eligible recipients to support claims processing, surveillance and utilization review activities, and management reporting.

2. Provider Enrollment

- a. Processes and enrolls providers upon their agreement to comply with Title XIX rules and regulations.
- b. Ensures that only qualified providers are permitted to render service.
- c. Creates and maintains a computer file on all eligible providers to support claims processing, surveillance and utilization review activities, and management reporting.

3. Invoice Processing

- a. Ensures that all claims and related transactions are accurately input to the system at the earliest possible time.
- b. Establishes strict system controls to ensure that all transactions are processed completely and promptly and that all claim discrepancies are resolved expeditiously.
- c. Verifies the eligibility of both the recipient and the provider and the validity of the claim information submitted.
- d. Ensures that correct payment is made to providers on a timely basis.
- e. Creates a computer file of adjudicated claims to support surveillance and utilization review activities and management reporting.

- f. Creates a generalized update facility for various reference files used in claims processing.
 - g. Provides Medicaid practitioner usual and customary charge data and incorporates Medicare usual and customary charges in the Medicaid system.
 - h. Generates various listings of claims suspended because of error conditions.
4. Surveillance and Utilization Review (This subsystem is described in more detail in following pages)
- a. Develops a comprehensive statistical profile of health care delivery and utilization patterns.
 - b. Reveals suspected instances of fraud or abuse of the Medicaid program by individual providers and recipients.
 - c. Provides information indicating the existence of any potential defects in the level of care or quality of services provided under the Medicare program.
 - d. Provides input to Medicaid policy and to invoice processing edits or screens.
5. Management and Administrative Reporting System (MARS)
- a. Furnishes the agency with information to support the management review, evaluation and decision-making processes.
 - b. Provides management with financial data for proper fiscal planning and control.
 - c. Provides management with information to assist in the development of improved medical assistance policy and regulations.
 - d. Monitors the progress of claims processing operations, including the status of provider payments.
 - e. Analyzes provider performance in terms of the extent and adequacy of participation.
 - f. Analyzes recipient participation in terms of the nature and extent of services received.

- g. Provides the necessary data to support Federal reporting requirements.

CONTROL MECHANISMS

In addition to the extensive edit system, including fee screens, built into the invoice processing component of MMIS which automatically reviews and evaluates data from claims submitted for payment to determine validity and appropriateness, and the Surveillance and Utilization Review subsystem, Michigan's medical assistance program includes other mechanisms designed to control or recover costs. Among the most significant of these are:

Prior Authorization: Specified program benefits available to those eligible under the medical assistance program are subject to prior approval. Under this program, providers of these services must prepare detailed treatment plans and submit them to the Division of Authorization and Claims Resolution, Bureau of Health Care Administration, Department of Public Health. Proposed services are there subject to review and evaluation by professional medical personnel. The prior authorization process is valuable in determining the appropriateness and effectiveness of treatment prior to its application, and can assist in monitoring quality of service and in preventing overutilization of expensive services.

Third Party Liability: Federal law requires that the State exhaust all known resources prior to utilization of Medicaid funds. The State, however, is prohibited from withholding payment when the third party resource is not immediately identifiable, liability has not been established, or the amount available is not immediately obtainable. In these circumstances, the State must identify available resources, ascertain legal liability, and seek reimbursement from the liable third party.

The early years of the medical assistance program (the third party provisions of the law took effect on March 31, 1968) were marked by an absence of significant activity in the area of identifying and exhausting third party resources. In early 1972, with the assumption of fiscal agent responsibilities by the State, the Third Party Liability Section of the Bureau of Medical Assistance was formed. This section was specifically charged with the identification and recovery of third party funds from such potential resources as other health, liability and workmen's compensation insurers.

Vague and conflicting laws, opposition from many segments of the insurance industry, and the absence of Federal guidelines

notwithstanding, the Third Party Liability Section has operated from inception at a successful cost benefit ratio, as demonstrated in this chart:

Fiscal Year	Cost	Recovery	Benefit/Cost Ratio
73/74	\$285,000	\$1.2 million	\$4.21/1
74/75	\$345,816	\$1.8 million	\$5.20/1
75/76*	\$313,040	\$2.1 million	\$6.84/1
76/77	\$555,000	\$4.4 million	\$7.90/1

*12 Month Fiscal Year

Moreover, this recovery program operates without causing delay, interruption, or deprivation of medical services to eligible persons.

Enhancements now being developed for this program will automate much of the resource identification process, allowing a recovery of a greater portion of potential third party resources. In addition, a medical support program is being implemented, in cooperation with the Michigan Friends of the Court, which will allow ready identification of resources available from absent parents required by court order to maintain health care benefits for their children. The net effect of these increased activities will be to greatly increase the funds recovered in the future.

Investigations: Under Title XIX, the single State agency is charged with the responsibility for determining when there is valid reason to suspect that fraud (or program abuse) has been committed and whether claims submitted represent valid obligations to the program. To carry out this function, the Investigation Unit (recently transferred from the Bureau of Medical Assistance to the Office of Inspector General of the Department of Social Services) conducts investigations of providers. Investigations may be initiated as a result of information received from a variety of sources, including referrals from the Department of Public Health on the basis of data generated from the Surveillance and Utilization Review subsystem. An examination and analysis of provider billings, program payments and provider office records is made to substantiate the accuracy and legitimacy of billing and payment. As a deterrent to program abuse and fraud, and as a mechanism to recover overpayments, a determination is made as to actual delivery of medical services and an evaluation made of provider pricing policies and practices.

Major functions of this section include:

1. Specialized in-office and on-site reviews and investigations of providers' billings and related records.
2. Verification of services performed by examination of providers' records and direct contact with recipients.
3. Profiling and analyzing claims in suspected situations of overuse, misrepresentation or other program abuse by providers and recipients.
4. Verification of compliance with all rules, regulations and procedures of the program by providers and recipients.
5. The development of cases which may lead to refund, removal from program participation and/or criminal prosecution.

The Investigation Section's review is primarily fiscal in nature, but coordinated with and supported by the Michigan Department of Public Health which serves as a medical professional consultant. Public Health Medicaid program review findings are coupled with other fiscal and administrative evidence to build a case for and by the Investigation Section. This Section works very closely with the Department of the Attorney General in investigating and bringing cases to the point of prosecution.

In the first year of operation, fiscal year 1973-74, the Investigation Section recovered in refunds to the program approximately \$1 million. The collateral effects of this review and of the handling of billing practices by involved providers created an additional cost avoidance to the program of approximately \$670,000. During 1974-75, actual refunds were \$1.2 million with associated cost avoidance for that fiscal year of \$560,000. Fiscal Year 1975-76 refunds were \$1.4 million with cost avoidance of \$685,000. Refunds in FY 1976-77 are expected to approach \$1 million. This decline is a result of organizational and procedural changes and the temporary assignment of some staff to the Attorney Generals' investigation activities. It is expected, however, that as the unit's efforts are refocused, refunds will recover in the next year.

SURVEILLANCE AND UTILIZATION REVIEW

The Surveillance and Utilization Review Subsystem of MMIS was developed to accomplish the following primary objectives:

1. Develop, over time, a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in the various categories of service authorized under the Medicaid program.
2. Provide information which will reveal and facilitate investigation of potential defects in the level of care or quality of service, potential misutilization, and promote corrective action of individual participants in the Medicaid program.
3. Accomplish the substantive objectives above with a minimum level of manual clerical effort through the efficient use of analytic and professional medical expertise, and with a maximum level of flexibility with respect to management objectives.

The basic approach employed by Surveillance and Utilization Review in achieving these objectives is the technique of exception reporting. Within the context of the Medicaid program, exception reporting involves the following major functions:

1. Maintain such data on the activities and characteristics of individual Medicaid participants as may be obtained from paid claims and from provider and recipient enrollment procedures.
2. Classify participants into peer groups according to demographic, medical and utilization characteristics.
3. Develop a statistical profile of each peer group classification to be used as a base line for evaluation.
4. Develop a statistical profile compatible with the peer group profile of each individual participant.
5. Automatically compare each individual participant profile to the appropriate group profile.

6. Report, as suspected misutilizers, all individual participants who deviate significantly from their group norm or from predetermined standards.

The Surveillance and Utilization Review Subsystem, as implemented in Michigan, is designed to accomplish the required reporting functions through six main modules or processes. These modules are the provider module, the recipient module, treatment analysis module, report writer modules, interface module and the control module.

V. STATE APPROACHES TO REGULATING MEDICAID EXPENDITURES

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THE NEW JERSEY RATE-SETTING
EXPERIENCE

In 1971, the New Jersey legislature enacted the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. This innovative legislation vested wide regulatory authority in the New Jersey State Department of Health. The objectives of the Act were to use the health planning process established by Federal legislation as the means to appropriately allocate resources for the health care of citizens in the State. In order to implement the recommendations of the planning process, the Act established a Certificate of Need program for all health care facilities in the State, created a rate review program for Blue Cross and governmental payors, transferred the licensing and inspection programs for health care facilities to the Department and permitted the Commissioner to gather all pertinent data.

When Joanne E. Finley, M.D., M.P.H. was appointed Health Commissioner in 1974, there existed an initial State Health Plan and a Certificate of Need program. However, the latter program had no established standards or criteria against which Certificate of Need applications could be judged. The rate review program never had been instituted by the Health Department, such reviews being left to the Health Research and Educational Trust of the New Jersey Hospital Association. In order to implement the will of the legislature, Commissioner Finley instituted the rate review program in the Health Department and insisted that a careful integration of planning with the regulatory activities be undertaken. Her directive emphasized that the prevention programs run by the Department should be given greater consideration by the health planning activities.

There are two fundamental goals of the rate review program. The first goal is to reinforce and implement the planning decisions. The second is that controllable hospital cost increases are expected to be at no greater rate than that for the rest of the economy.

The rate review system compares base year costs among similar facilities, identifies costs which appear to be unreasonable and disallows them unless the hospital can explain why they are necessary. The approved base costs are then inflated by a price factor, adjusted for changes in patient volumes and for any approved expenditures resulting from Certificates of Need, mandated cost increases (by FICA) and approved management changes.

The effectiveness of the system can be seen in that for the covered payors, i.e. Blue Cross and Medicaid, the rate of increase in approved total expenditures has been about ten percent per year since the program was instituted. Specific changes in hospital activities resulting from the program can be identified, such as the very rapid increase in the use of shared services and joint purchasing programs.

It is the Department's view that long run cost reductions in health care costs in the State of New Jersey will not be affected by eliminating excess operating expenditures in hospitals. Once any "fat" in hospital budgets is eliminated, then a basic level of price inflation plus adjustments due to the intensity of care will continue to lead to annual cost increases. Therefore, it is necessary to provide more preventive care so that citizens do not need to be treated in the first place, and to create a system to provide appropriate care for the citizens at the least cost possible. As examples, it should be possible to move patients from acute care into convalescent care reasonably rapidly and to provide care in a home environment where such care is appropriate without placing them in institutions. Not only would health care costs be reduced, but the general environment of the citizens will be vastly improved by such a carefully structured system. A major problem with the development of such a system is that many payors do not reimburse for non-institutional care. The cost reductions resulting from taking people out of institutional care have to be weighed against the potential increases in demand due to the extension of coverage to new classes of beneficiaries.

Within the health care facilities themselves, a major factor in cost reduction is limiting the introduction of sophisticated technology. This is particularly true if, as is frequently alleged, knowledge of the affects of the change in technology on patient health status is unknown. One issue to be confronted by government is that the volume of medical care delivered in the United States today is such that small changes in health status result from exceedingly large increases in expenditures.

Another cost-containment approach to be reinforced by rate review is the regionalization of services in order to decrease the proliferation of highly sophisticated care, and to reduce underuse of facilities and staff and duplication of effort. New Jersey has established various regionalization regulations for specified services. One issue yet to be faced is that these services cannot be distributed among hospitals when similar ancillary services must be available to each of the specialized services involved.

New Jersey currently has a contract with the Health Care Financing Administration to develop a reimbursement system based on patient case-mix. Currently negotiations are underway with 18

hospitals, from the State's total of 105 general acute hospitals, to reimburse them prospectively for their case-mix of patients. As a result of a major developmental effort in the past two years, the State has allocated a cost to various medically related groups of patients called Diagnosis Related Groups (DRGs). An allocated cost has been developed for each of 383 patient care groupings for the hospitals involved in the experiment. A budget has been constructed, based on the anticipated volumes of such patients to be treated so that the financing of care can be related to the type of care required. Since the cost is being developed on the basis of a case rather than a per diem, the incentives of the system are to reduce length of stay and the use of patient care services. There is an incentive to increase admissions which has to be taken care of through appropriate utilization review and related programs. However, it is possible to develop a variable budget to eliminate the incentives to unnecessarily admit patients.

It is essential that legislators who are attempting to develop a cost containment system examine the entire health delivery system. For example, one problem with the New Jersey rate review system is it has authority over only 40 percent of the payments made to hospitals. Legislation is pending in New Jersey to extend that authority to cover all payors and all charges, in relationship to total hospital budgets. It is also essential that any budget review program be tied into health planning, Certificate of Need and licensing activities. A separation of the management of these responsibilities often leads to conflicting decisions by the governmental agencies which leaves the health care delivery system in a turmoil.

The total reimbursement of capital is related to the Certificate of Need program, and increasingly it seems apparent that it will be necessary to set some ceiling on the reimbursement of capital expenditures. One possibility is to take the current asset value of facilities, annualize the cost of maintaining and replacing such capital and use that value as the ceiling for issuance of Certificate of Need. One problem with that approach is it assumes the existing capital allocations are appropriate.

If budget review is undertaken vigorously by the State agency, that agency can be expected to be taken to court by the hospitals; such a result should be no surprise to the legislature. To the extent that the health planning activities and the associated regulatory programs of budget review and Certificate of Need are effective, there will be increasing political pressures placed on the legislature from hospitals and other interest groups to either pass special legislation to override particular decisions, or to eliminate the programs in their entirety. If legislators are interested in reducing the cost of health care to citizens of

their States and in better allocating the resources used for that care, such pressures will have to be resisted.*

*The 1978 New Jersey legislature enacted a bill, later signed by the governor, establishing a Hospital Rate Setting Commission within the State Department of Health.

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Maryland Health Services
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THE MARYLAND HEALTH SERVICES
COST REVIEW COMMISSION

STATE REGULATORY APPROACHES

There are a vast number of different possible State approaches to the regulation of hospital costs. I will describe the approach used by the Maryland Health Services Cost Review Commission (MHSCRC) in some detail, and then explain the major differences between this and the approaches used in some of the other States which have operational hospital regulatory agencies.

THE ADMINISTRATIVE FORM OF THE COMMISSION

The Maryland commission consists of seven part-time members, appointed by the governor. Four of them must have no connection with a regulated institution. For comparison, Washington, Connecticut, Massachusetts and Colorado have commissions, and in Massachusetts and Colorado the commissioners are full-time. In New Jersey, New York and Rhode Island the regulation is enforced by a State agency, with assistance from Blue Cross and/or the insurance department. The MHSCRC came into being in 1971. Between 1971 and 1974, it could only disclose information but could not regulate. On July 1, 1974, it assumed responsibility for hospital rate regulation.

In Maryland, the commission regulates the rates that a hospital can charge in each of its service centers -- for example, the medical/surgical unit, the radiology department and the laboratory. A rate per unit of service is set and the hospital has to ensure that, on average, this is the charge that is made. In medical/surgical or obstetrics that unit would be a patient day, in radiology it would be a relative value unit and in a laboratory a College of American Pathologists workload unit. Also, we are regulating the average charge per admission in some hospitals. Setting departmental rates has some considerable advantages since it ensures that the charges are based on the actual departmental costs and any cross-subsidization desired has to be built deliberately into the system. In Connecticut and Rhode Island, the regulator specifies the total hospital budget, in New Jersey and New York a per diem rate is specified. In Washington, an experiment with three different systems is taking place -- total budget, rate per unit of service and retrospective cost-based reimbursement.

APPLICATION OF SYSTEM IN MARYLAND

A rate review can be initiated either by a hospital desiring a rate increase, or by the commission. The first step is the submission by the hospital of a rate review system. This gives the actually experienced costs and volume of service, department by department, for some base year -- usually the most recent full fiscal year. The figures are projected forward taking inflation, budgeted volume changes and new programs into account. The commission staff checks the rate review system for errors, and when these have been corrected, they begin a screening process. The purpose of the screens is to pinpoint costs which can be considered presumptively unreasonable. The first step in the process is to adjust the wage and salary costs to eliminate the effects of regional variations in wage rates, and to level all the costs to some fixed point in time. All the management and administrative costs are lumped together, and the cost per patient day computed. If this is below the median for all hospitals, the cost is presumed to be reasonable and no further analysis is done. If the cost is above the median, then the costs per appropriate unit of measure are computed for each overhead center and are compared with the same costs for other hospitals. If the costs are above the 80th percentile, they are considered unreasonable and challenged. The 80th percentile screen also is applied to the cost per unit of service in each patient care center, and all costs over the 80th percentile are considered presumptively unreasonable. These are discussed with the hospital staff to determine if the apparently excessive costs are, in fact, justified. An example in which it was decided that the costs were justified was in housekeeping at John Hopkins Hospital. In that case the cost of housekeeping was extremely high, but the main reason was found to be the design and age of the hospital buildings. Since we could not suggest any method of reducing the costs, the challenge was eliminated. The staff prepares a recommendation that is sent to all interested parties, the hospital and the commissioners. This is presented formally at a public meeting. If all parties concerned are in agreement (Blue Cross, the Health Insurance Association, Medicare, Medicaid, the Commission, the Legal Aid Bureau and the hospital), an order specifying the rates the hospital can charge is issued. If any party objects, the commission holds a public hearing on the controversial items. After hearing the testimony, the commission makes its decision. If any of the designated interested parties contests this decision, their appeal must be made in the courts.

We feel very strongly that any State rate regulatory body should design its procedures so that there is adequate consumer representation. In the case of hospitals, the powerful consumer bodies are Blue Cross and the Health Insurance Association of America. They, and other interested consumer groups, should have standing to appeal the decisions of the commission, in the same way

that the hospital can appeal its decisions. If there is no consumer appeal right, there is a strong temptation for the regulating agency to concede to the hospital. For, if it concedes, there is no appeal, but if it decides against the hospital, the hospital is likely to continue appealing as long as possible.

FREQUENCY OF RATE REVIEWS

It is our intention to review hospitals every 3 to 5 years, or possibly even less frequently. This may seem like a very long interval between reviews, but we think that there are substantial advantages to having infrequent reviews. This permits recognition of inflation in the intervening period, to allow for reasonable increases in factor costs. There are four major advantages to infrequent reviews.

1. With reduced number of reviews, the commission staff can spend much more time and effort on each one. As a result the reviews are more intensive, and also more fair to the hospital.
2. With a flexible schedule, the commission or the hospital can initiate a review at any time.
3. Because hospitals know that it is likely to be several years before they are reviewed again, there is a strong incentive to implement cost savings and reap the benefit of these savings over several years. If reviews are performed every year, a hospital may be loathe to cut costs knowing that at the end of the year they would no longer get the cost savings benefit, and that the subsequent year their cost-base would be reduced correspondingly.
4. Performing rate reviews is like going in with a knife and cutting parts out of the hospital's budget. Making a hospital live within a fair, but tight, inflation adjustment system places continual pressure on the hospital to eliminate fat from its budget. The hospital has more time to respond to the latter and is less likely to fight, and I think that the gentle squeeze has a much greater impact in the long term.

Many of the other regulatory agencies carry out reviews on an annual basis. Connecticut and Rhode Island are two examples. At this point it is probably worth digressing to discuss the systems used in other States.

OTHER STATES' SYSTEMS

The system used in Rhode Island is the least like the Maryland system. The plan is run by the State budget director with Blue Cross of Rhode Island. They, together with the hospital association of Rhode Island, decide on a MAXICAP. This is a Statewide upper limit to be placed on hospital aggregate gross operating expenses. The hospital budgets are negotiated individually, but subject to the limitation that the total over all hospitals has to be less than the MAXICAP. In most of the other States carrying out hospital rate regulation the control is by means of annual reviews.

The use of cost screens is very widespread, although the precise details of the screens vary considerably. In New Jersey, they are expressed in terms of percentages of mean costs, in Maryland as percentiles, and in Washington, the 50th percentile is used and is applied to expense per adjusted admission and per adjusted patient-day in the primary screening process.

INFLATION ADJUSTMENT SYSTEM

The inflation adjustment system is the cornerstone of the Maryland system. We have developed a system which estimates what the increases in costs in hospitals should be, if they are operating efficiently. There are two major cost categories that have to be considered, salaries and supplies and contracted services. Rate regulation of hospitals will not be effective unless an attempt is made to control the increases in wage and salary costs. In Maryland, we allow the increase in the Consumer Price Index as the inflation factor for wages and salaries. The hospital is not obliged to hold to this amount in its wage negotiations, but this is the increase that will be allowed in rates. If the hospital pays less, they keep the difference, and if they pay more, they must absorb it or improve efficiency. The factor for supplies and contracted services is a composite index made up of components of the Wholesale Price Index and Consumer Price Index and same inflation factors determined from actual hospital experience for supply categories for which suitable proxies are unavailable.

INCENTIVES

The major problem with most reimbursement systems tried to date is that they do not contain financial incentives to the hospital to operate in the public interest. In fact, the incentives are almost always in the wrong direction. For example, in the Maryland system the incentive in the past has been to drive

up the volume of service provided, because in that way the unit costs are reduced, and so the costs are less likely to be challenged in a rate review. We are working towards a more refined system in which this perverse incentive will be eliminated. The state-of-the-art in reimbursement systems are systems which incorporate positive incentives to the hospital to reduce utilization of services, and to make use of case-mix data in the development of the charge to the patient, or at least in the total reimbursement to be made to the hospital.

The major reason why hospital costs are increasing much faster than costs in other parts of the economy is that more services are being provided to patients having the same illnesses. I will refer to this phenomenon as intensity increase. To date, little has been done by regulatory agencies to control intensity increases. However, much thought is being devoted to designing reimbursement systems that will give hospitals an incentive to control intensity increases, and, where possible, to reduce the average length of stay and intensity of the service being provided. I will describe briefly two of the systems being developed toward this end.

THE GUARANTEED REVENUE PER ADMISSION

The MHSCRC currently is experimenting with a new reimbursement system involving a guaranteed revenue per admission (GRA). The idea is that the MHSCRC sets a GRA for a hospital based on its previously experienced revenue per admission. This GRA is adjusted for inflation, volume changes and changes in the hospital's case mix. The GRA is both an upper and a lower limit on the average revenue per admission for the hospital. The result is that, if the intensity of service continues to increase, the hospital does not get paid for the extra tests, or extra days involved. However, if it manages to reduce the length of stay or intensity of services, it gets paid in full for each test or each day eliminated, while incurring none of the costs of these services. The incentives of this system are obvious.

DIAGNOSTICALLY RELATED GROUPS (DRGs)

In a New Jersey experiment, hospitals will be paid on the basis of diagnostically related groups (DRGs), which are groups of cases that are expected to be similar in length of stay or cost. The parameters that determine which DRG a case will be assigned to include primary diagnosis, age, sex, existence of other diagnoses and medical or surgical treatment. The latest set of DRGs consists of 383 groups. The idea in this system is that a charge will be associated with each DRG and any case falling within a DRG will be charged that amount. This system incorporates the same incentives

as the GRA being used in Maryland. While this system is feasible in New Jersey where it will be applied only to Blue Cross, we do not consider it to be suitable for Maryland where the rates set by the Commission apply to self-pay patients.

VI. ISSUES IN MEDICAID REIMBURSEMENT

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INSTITUTIONAL REIMBURSEMENT
UNDER MEDICAID

Under the Medicaid program, some 70 cents out of every dollar is spent for nursing home care and hospital care. Obviously, Medicaid's involvement in this area, in terms of economics and public policy, is quite significant.


NURSING HOME SERVICES

The typical State's payment for nursing home services will consume 35% to 40% of its Medicaid budget. The market conditions under which nursing home services are available are pertinent to understanding Federal Medicaid regulations. Unlike physicians' services and hospital services, which are used by the entire population, nursing home services tend to be used mainly by Medicaid patients. Nationally, Medicaid patients comprise almost 70% of the nursing home census. The nursing home industry arose with State welfare payments and depends upon State Medicaid payments for its existence. Thus, the market consists of a single major buyer in each State and 20,000 suppliers (nationally). Under such conditions, we would expect the State as a monopsonist (a single large purchaser) to specify the details of the product it will purchase and to negotiate its price. And that is just what Federal Medicaid regulations permitted. Prior to July 1, 1976, Federal requirements pertaining to State methods of payment were simple: payments for care could not exceed amounts which would be determined using Medicare's principles and standards of cost reimbursement. However, States also establish conditions of participation which relate to facility structural safety conditions and patient care standards. To assure that the level of reimbursement was sufficient to meet the quality of care standards required, Congress enacted new reimbursement requirements which went into effect last year.

Effective July 1, 1976, a new provision in Title XIX of the Social Security Act requires that payment for long term care services must be on a reasonable cost-related basis. HEW regulations issued July 1, 1976, define conditions which States must meet in establishing systems of payment (42 Code of Federal Regulations 447.274, 447.292, 447.278, 447.301, and 447.311). Each Medicaid State plan must:

1. Provide for uniform cost reports.
2. Provide for field audits of all nursing home cost reports.
3. Set forth the items of expense which are allowable costs.
4. Establish reasonable methods of determining the payment rates.
5. Assure that the bottom line will be paid (i.e., in contrast to basing payments on available State funds).

Methods of payment established by the State may vary as follows:

Basis of Payment	Retrospective System		Prospective System	
Individual Facility Rates	Up to a Cost Ceiling	No cost Ceiling	Up to a Cost Ceiling	No Cost Ceiling
Class Rate			Uniform Class Rates	

That is to say, methods of payment may be:

1. Retrospective -

A final settlement is made at the end of an accounting period based on audited costs of each individual facility. Under such a method, there could be ceilings on costs or not, as the State chooses. If there are no ceilings on costs note that the payment method is the same as that used under Medicare.

2. Prospective -

Payments made during the accounting period are final (there are no adjustments). Under a prospective method of payment, a uniform class rate may be paid (all facilities in the class get the same rate) or a rate may be based on each individual facility's costs. Also, the State has an option of placing ceilings on costs or not, as it chooses.

3. Combination prospective and retrospective -

It is possible to combine prospective payment for some cost elements and retrospective payment for other cost elements into a single plan. For example, payment for routine care costs (i.e., room, board, and basic nursing services and supplies) could be on the basis of a

prospective uniform class rate and payment for ancillary costs (i.e., drugs, physical therapy, etc.) could be on the basis of a retrospective cost-settlement.

A description of Medicaid State plans for reimbursement of long term care services ("Report On Systems of Reimbursement for Long-Term Care Services") has been prepared by HEW. However, since that report covers States' methods in effect before the new regulation was issued July 1, 1976, there will be elements in the plans described which are not acceptable under present requirements for reasonable cost-related reimbursement. Regardless, the report outlines the great variety of methods of payment possible. Another volume in the same study analyzes the various State payment systems in terms of methods used to pay for depreciation costs, salary costs, etc.

Additionally, an important study of nursing home costs was prepared in January, 1976, by the New York State Moreland Act Commission. Its reports "Reimbursement of Nursing Home Property Costs: Pruning the Money Tree" and "Dollars Without Sense", are valuable source reading in the formulation of public policy in this area. In June, 1977, the Urban Institute in Washington, D.C., published a very thoughtful and concise study well worth reading. The study notes that methods of payment may be based on a facility's historical costs of the individual nursing home (Facility-Independent Reimbursement). The study concludes that methods of reimbursement which are facility-independent have a greater potential for containment of costs. Such methods are based on determinations of standard costs.

HOSPITAL REIMBURSEMENT

Hospital reimbursement captures some 35 percent of the typical States' Medicaid expenditures. However, Medicaid patients, on average, comprise only 15 percent of the average hospital's patient census. Although Blue Cross is the major purchaser, combined payments from third-party payers, Medicaid, Medicare, and Blue Cross, supply over 80 percent of the average hospital's revenues. In most States, the economic situation is that of a hospital (monopolist) making available its services at a cost tied to the rate of production of the U.S. Treasury's printing presses.

The Medicaid regulation covering requirements for payment of hospital services, up to November, 1971, was a prime contributor to the inflationary situation. The regulation required that payments had to be determined according to the methods and standards used for cost reimbursement by Medicare. That is to say, payment had to be based on each individual hospital's allowable costs, no matter how much such cost varied from costs of peer institutions. The

effect of such requirements has been an increase in hospital costs alarmingly in excess of cost trends in the pre-Medicaid/Medicare era. In 1971, Medicaid changed its regulation to permit States to define reasonable costs uniquely, (i.e., the regulation no longer stated that Medicare's method of determining reasonable costs was the only method which could be used).

Under the revised provisions, for example, New York has received HEW approval to place ceilings on costs based on peer comparisons, and to place ceilings on projected expenditures based on the expected increase in the costs of goods and services comparable to those used in the provision of hospital services. Alternative methods of reimbursement (outside of Medicaid) have taken various forms:

1. Some State legislatures have established Rate-Setting Commissions which regulate hospital charges. Thus, the Commission's rules affect hospitals' revenues regardless of the payment practices of third-party payors.
2. In other States, the methods used vary from an intensive review of each individual hospital's use of resources to the exact opposite (i.e., where a formula is used to establish payment rates).

SUMMARY

To conclude, Medicaid's regulations allow each State to determine its methods and standards for payment of nursing home services and hospital services. In the case of hospital services especially, a number of State Medicaid agencies have exercised the option to pay for such services on a basis that focuses hospital attention on cost containment: States such as Colorado, Massachusetts, and New York among others. I invite you to inquire into the subject in your State.

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NURSING HOME REIMBURSEMENT REFORM:
THE MINNESOTA APPROACH

BACKGROUND

By way of background, Minnesota has more nursing home beds per capita than the other States. We have doubled the number of nursing homes in the last ten years. Once we started paying for nursing homes under Medicaid or medical assistance, as we call it in Minnesota, the number of homes just increased dramatically. The nursing home industry in Minnesota includes about 40% proprietary homes, 40% non-profit homes, and the rest governmentally owned homes. About 63% of our nursing home residents are on Medicaid. We spend about \$200 million a year on nursing homes, which is the largest State expenditure except for educational programs.

The impetus for what we did was a series of scandals involving nursing homes in Minnesota. Within the space of a year about 1% of the nursing homes owners in the State were convicted of various types of criminal fraud. The scandal spilled over so that there were some former legislators who were almost indicted by the Grand Jury; they were accused of violating the public trust. The county attorney for our largest county received interest free loans from a nursing home. He did not pay them back until the investigators started looking at the loans. The two departments of the State involved, the Health Department and the Welfare Department were also tainted. The person in charge of regulating nursing homes in the Health Department was fired and his assistant was suspended and transferred to another part of the Health Department because of allegations of too close a relationship with people in the industry. The public examiner's office issued a report criticizing the Welfare Department for the way they were auditing nursing homes costs reports.

All of this public turmoil and publicity led to a joint-select committee on nursing homes which developed an eight-bill package. All of the bills passed easily in the 1976 session. The scandals created such a public outcry that many legislators were reluctant to vote against any nursing home bill. Also, with several of the nursing homes operators being involved in criminal actions, the lawyer for the nursing home association was tied up in court and was not able to help them in the lobbying efforts to the extent that he normally would.

GENERAL LEGISLATION

Three of the bills dealt with Medicaid related issues. One set up a fraud unit within the Department of Welfare to perform surveillance and utilization review functions.

The second one made it a specific crime in Minnesota to steal from the Medicaid program. Before the legislation, it had not been a specific crime. The attorney general, in attempting to convict people, had to utilize the general theft statutes. He found that to be a very difficult situation. He asked for and was given a separate statute that made stealing from Medicaid a specific crime. That same bill also gave the Department of Public Welfare power to look at records of providers to determine whether or not fraud had occurred.

The third bill dealt with Medicaid reimbursement.

REIMBURSEMENT LEGISLATION

The Research: The really key Medicaid bill was one to partially write into law the State's nursing home reimbursement formula. We previously had an agency rule which was developed by an accounting firm and had been in effect for several years. During the joint subcommittee hearings, we found that the welfare commissioner and assistant commissioners had the wrong impression of how the rule was being enforced within the Department and how limits were being applied. What actually was going on was somewhat different from their impression. For example, the Department assumed that they were not reimbursing nursing homes for interest on loans in excess of the value of the facility. We were able to obtain the services of an auditor from the State auditor's office. He examined several cost reports and found that the Department was paying interest on loans in excess of the value of the facility. We found one home which obtained a second mortgage and used the money to build an apartment building. The State was paying interest on both the first mortgage and the second mortgage, when the proceeds of the second mortgage were used to build a separate outside enterprise.

In developing the data for our bill on the issue, we utilized computer data which was prepared by the Department of Public Welfare. They were able to tell us the average rates for metropolitan and rural facilities; for proprietary, non-profit and governmentally owned facilities; and so on. That did not get us too far in determining appropriate policy. Using our auditor, we did an indepth study of about 15% of the nursing homes in the State. They were selected by geographic mix, size mix and types of ownership mix. Through this, we were able to spot what the

legislators concluded were some serious problems in the area of reimbursements, especially with respect to property related costs.

At the same time, we were receiving public complaints about nursing homes rates, and about the differential between private pay rates and public pay rates. With the combination of what we found in the study, and what the public was complaining about, we drafted the bill which eventually passed.

Investment Allowance: The first area we addressed was the return on investment. We found facilities that were in debt in excess of the value of the facility. This meant that the Department was giving them a return or profit on an assumed equity that in most cases did not exist, in addition to paying interest on loans in excess of the value of the facility. We found the rate of return on actual equity varied from about 26% up to an 1,850% return. (In homes where there was a negative equity, it was impossible to compute a rate of return. The operators were being paid a profit on a non-existent investment.)

After considering various options, the legislators developed a concept for proprietary homes which annually gave them 9% of the value of the facility as an investment allowance. In effect, they told owners that if they got loans on the facility, they would have to use that 9% to pay the interest. But if they had equity in the facility, then that 9% would be their profit. If the 9% figure has to be changed, due to changing interest rates or other factors, the Department of Welfare can change it from year to year. For the non-proprietary homes, the amount was set to 2% because they do not have as great a need for profit. (We found that not all non-profit homes are really non-profit homes; the largest scandal involved a supposedly non-profit home. The owners were making some good money on it.) In addition, the law provides that, after the same owners operate a non-proprietary home for three years, there is a limit on how much debt they can have. They can no longer keep on leveraging the facility, and have the State keep paying their interest.

The intent of these changes was to try to discourage people who only get into business for investment reasons, and to encourage owners operating the facility as their business.

Quality of Care: The secondary question we tried to address was quality of care. How can you relate quality and efficiency to a nursing home reimbursement rate? In our study of homes, we did a correlation, a very crude one, of costs and quality. The only quality standard that we could really identify was the number of times a home had been fined by the Health Department for violation

of standards. We found that the higher cost homes tended to have a worse record. They are more expensive to operate and of lower quality, if you accept that definition of quality. The members of the joint subcommittee struggled with trying to find a way to build into the reimbursement rates some incentive for quality and efficiency. They were not able to come up with much and were advised by our State Welfare Department that the Federal government would not let us do it anyway. In that area, nothing significant was achieved.

Turn-Over of Ownership: The third major problem that we tried to address was the turnover in ownership. The way the Department's rule was operating, the purchasers of a facility were generally reimbursed for whatever they paid for the facility. Therefore, the purchaser did not care what he paid for the home. The sellers could make a lot of money because the buyers did not really care what they paid. This led to a tendency of investors to buy a home, keep it for a few months, and then sell to somebody else.

That was bad for a number of reasons. First, frequent turn-over of ownership does not lead to quality care. Second, as the owners kept raising the price each time the home was sold, the Welfare Department was paying more to reimburse the new owners for the purchase price. This meant that they also paid higher depreciation and more interest payments on higher loans. There was really no incentive for the owner of a home to keep the home.

In an effort to get at these problems, two things were done. First, the law instituted a provision for an appraisal at the time the facility was sold in order to prevent artificially high purchase prices. Second, the law instituted a system which provided that the home would be reappraised every few years if it continued under the same ownership. If the owner kept the home, and if it was going up in value, the only way prior to that which he could get his increased value was to sell the home. Under the new system, a continuous owner could get a reappraisal and his property reimbursement rate would go up every few years. It was hoped that this might be an incentive to keep a home rather than sell it. The industry did not like the provision and they came in with the new proposal in 1977. This was accepted and the law was amended so that instead of a reappraisal, the home's 9% investment allowance goes up slightly every year the home is owned by the same owners. It was a further attempt to encourage people to keep the facility and operate it as a business rather than treat it as an investment.

Related Issues: Several other areas addressed were not directly reimbursement issues, but the legislators used the reimbursement bill to try to address some related questions. The public was complaining that while they supposedly had the choice of vendor under medical assistance, homes were requiring residents to use doctors and pharmacies selected by the home. Other complaints from the public came on the rate differential between the public pay patients and the private pay patients. This varied from about 5% to a 40% differential in rates. People said, "Why does my mother have to pay more than the person on welfare for the same services?" There was some question as to whether or not we could legally address that problem. The third public concern was over admission fees or application fees for admission, and over homes which said, "We will admit you but you have to sign over your estate to us before you can come in."

In an effort to address these problems, the law made it a condition for Medicaid eligibility in the State, that the home would have to agree (1) not to have a rate differential between public pay and private pay in excess of 10%, (2) to allow a free choice of vendor, and (3) that it would not charge any admission fee or require the potential resident to turn over his estate as a condition of admission. The industry has gone to court on some of these requirements. The legislators used this approach because it gives the home an option. If they do not want to comply with those conditions, they do not have to take Medicaid patients. Of course, it is very difficult for a home to survive without Medicaid patients. Most homes could not get by without them. From a legal point of view, this approach may get by in court.

Excluded Costs: The last area addressed was the one of what costs should be excluded from the reimbursement formula. The legislature ended up excluding items such as political contributions, lobbying expenses, advertising, and so on. Homes were to be denied reimbursement for these costs.

Briefly, that is the way we got where we are, and the issues we tried to address in the Minnesota nursing home reimbursement bill.

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MEDICAID HEALTH MAINTENANCE
ORGANIZATIONS:
EXPECTATIONS AND EXPERIENCE

The extraordinary increases in Medicaid expenditures over the past few years have forced States to experiment with cost containment strategies that attempt to improve efficiency with the existing system or create an alternative mode of delivery. The alternative has been embodied in the term Health Maintenance Organizations (HMO).*

HMOs were officially ushered onto the Federal policy scene by the Nixon Administration in 1971. Based on the experience within large prepaid group practices, HMOs were billed by the Federal government as a delivery system that would (1) lower costs, (2) provide comparable quality of care, (3) produce general consumer satisfaction, (4) maintain health, (5) provide a "comprehensive" as well as tightly coordinated benefit package to its enrollees, (6) bring mainstream medicine to the poor and aging, (7) rectify the practice of "cream skimming" engaged in by major third party fiscal intermediaries, (8) introduce competition into the medical marketplace and (9) remove the need for increased government intervention in the health care system while at the same time acting as a fiscal tool for Federal and State health program.[1]

If the Federal government's interpretation and vision of HMOs were correct, then the States would have a great deal to gain by transferring their Medicaid clients into HMOs. The transfer would improve the States' ability to budget program expenditures accurately, simplify program management, eliminate the fraudulent and abusive practices directly linked with fee-for-service -- such as billing for undelivered services or providing unnecessary care -- and, most importantly, contain costs. At the same time, the State could offer the recipient direct access to organized medical services. The promise of increased access to comprehensive care and the systematic provision of preventive medicine, made mainstream medicine seem like a feasible objective.

* HMOs are "organizations which provide comprehensive health services to voluntarily enrolled consumers, on the basis of fixed price -- or capitation contracts."

A basic problem with the Medicaid HMO strategy is that Medicaid clients are not evenly distributed throughout a State. Clients tend to be concentrated within the inner cities of large metropolitan regions. If the HMOs are to be accessible to recipients, they must be located near or within poverty neighborhoods. However, that location discourages enrollment of non-Medicaid members. The situation is compounded by a phenomenon of residential "tipping". Tipping suggests that neighborhoods are unable to maintain a heterogeneous mix of residents, once the poor households grow beyond some critical percentage of the neighborhood. It has been estimated that this point is roughly 20 percent of the residents.[2] Once this tipping point is reached, the demographic structure of the neighborhood changes quickly. Middle and upper-middle income families move out rapidly, while more poor families move in. Under current regulations, an HMO's Medicaid membership may not exceed 50 percent of its total enrollment, although that regulation may be waived if an HMO is approaching that balance.* If an HMO begins with 100 percent Medicaid clients, it is highly unlikely that it will attract non-Medicaid clients.

Because the unemployed and working poor would generally be unable to afford an HMO, an HMO must jump income brackets by starting with the very poor, sidestepping the working poor and seeking out the middle class. Marketing efforts for non-Medicaid patients are complicated by both geographic and socio-economic distance. It may be that 50 percent Medicaid enrollment is basically unstable, that is, well past the tipping point. It would seem that an HMO would have either a good deal more or fewer Medicaid enrollees than the maximum prescribed by regulation. For discussion, an HMO with a Medicaid membership greater than 50 percent of its total enrollment will be considered a Medicaid HMO. It would seem that the Medicaid HMO constitutes a major response to the Nixon Administration's health maintenance strategy. Lamentably, rather than extend mainstream medicine to the poor, this has served to legitimize the development of a more highly institutionalized form of welfare medicine.

* Editor's Note: A Public Health Service regulation covering Federal qualification as an HMO is waivable; Medicaid requirements in this regard are not.

Between 1971 and 1973, Medicaid HMO contracts jumped from 4 to 66 with a total HMO Medicaid enrollment of 371,000. HMOs accepting Medicaid recipients accounted for 55 percent of 119 HMOs in existence in 1973 and 80 percent of the 82 HMOs that became operational between 1971 and 1973. The well established prototype HMOs, which accounted for nearly one-third of all Medicaid enrollees, had become involved in the Medicaid program between 1966 and 1971 -- long before the term HMO had become an accepted part of health care jargon. Thus, the Health Insurance Plan of Greater New York (HIP) first enrolled welfare recipients in 1966; by 1973 it had 49,000 Medicaid enrollees. The San Joaquin Foundation first contracted with the State of California in 1968 and had enrolled 43,000 Medicaid recipients by 1973. Puget Sound became involved in Medicaid in 1969, Kaiser and Group Health Associates of Washington, D.C. in 1971. By 1973, these three plans had respectively enrolled 4,600, 2,800, and 1,000 recipients. In contrast 61 newly organized HMOs accounted for 270,000 Medicaid recipients enrolled in 1973. These HMOs enrolled an average of 45,000 Medicaid clients. By comparison, in 1974 all HMOs excluding HIP and Kaiser,* had approximately 10,000 enrollees including both Medicaid and non-Medicaid members. Nearly half of the 1974 HMOs had a total enrollment of less than 5,000.

These figures suggest that the average Medicaid enrollment in participating HMOs accounted for major portions of new HMO's membership. Support for this thesis comes from a variety of sources. A January, 1975, enrollment survey of 137 HMOs throughout the nation showed that the 29 HMOs with more than 50 percent Medicaid enrollment averaged over 90 percent Medicaid membership. The 24 Medicaid HMOs that became operational during or after 1972 averaged 95 percent Medicaid enrollment. Schlenker noted that the survey may have undercounted the number of Medicaid HMOs because only 137 of the 180 HMOs questioned responded and because a number of California HMOs were among the missing respondents.[3] In California, the State with the most extensive Medicaid HMO experience, 58 of the 77 operational HMOs in 1974 had Medi-Cal contracts. A survey that year of California HMOs revealed that of the 41 responding organizations, 27 reported that they enrolled Medi-Cal members and 21 indicated that Medi-Cal accounted for 75 percent or more of their total membership. Three years later, after considerable scandal and legislative and executive reform, all but one of the 18 HMOs with Medi-Cal contractual arrangements had more than 50 percent Medicaid enrollee membership.

* Kaiser and HIP accounted for 70 percent of the total HMO enrollees in the country.

In Michigan, former OEO Neighborhood Health Clinics phased out of OEO and into Medicaid. Detroit has served as the stage for this development. Medicaid enrollees constitute the largest proportion of the membership, in some instances the only membership, of these HMOs. In contrast, the Metropolitan Health Plan, a Detroit HMO formerly organized by the UAW in 1961, does not have a single Medicaid enrollee. Despite the fact that the Metropolitan Health Plan is the largest and oldest HMO in the area with a working and middle-class membership, the State has been unable to enter into a contractual arrangement with it to include Medicaid clients. Thus, functional segregation of Medicaid recipients has continued although the name of the delivery mechanism has changed.

THE MEDICAID HMO MODEL

Why should a predominance of Medicaid enrollees alter an HMO's activities? And, how would these changes occur? California has been the Medicaid HMO showcase. In response to a 1971 Medical Reform Act and the belief that \$150 to \$300 million could be saved through this alternative, the State embarked on a vigorous campaign to transfer as many Medi-Cal recipients into HMOs as possible. The first HMO contract was signed in May, 1972. By the end of 1972, nearly 150,000 recipients were enrolled in 21 HMOs.

In 1974, 55 HMOs had signed up 247,000 Medi-Cal clients. As the HMO activity peaked, a series of State and Federal investigations began to report a series of program irregularities. Inappropriate and fraudulent HMO marketing practices were common. For example, clients were told that their Medicaid coverage would lapse unless they signed up, benefits were exaggerated, and recipients were not told that they would no longer be able to use their old physician or pharmacist. There were indications of gross under-utilization of services. One study showed the Medi-Cal recipients in prepaid plans experienced 36 percent as many hospital admissions and hospital days as fee-for-service Medi-Cal recipients and 15 percent of the nursing home days utilized by recipients in the fee-for-service system.

Horror stories abound about denials of emergency care and poor treatment. A 1974 study by the California Auditor General revealed that 52 percent of the \$56 million paid to 15 Medi-Cal HMOs went toward administrative expenses and profits.* Legislators and former executives from the Reagan Administration often acted as middlemen for new HMOs, facilitating the Medi-Cal contract. This raised charges of conflict of interest. The list of abuses is as unappealing as it is disturbing. Subsequently, tighter legislative and administrative actions resulted in a decline in the HMO program. As of March, 1977, 18 Medi-Cal HMOs served a total enrolled population of 150,000 clients.

The California experience does not mean that all HMOs are inadequate or undesirable. Nor does it mean that HMOs cannot adequately serve Medicaid recipients. Certainly the Medicaid experience with Group Health Association and Kaiser shows it is possible. California does suggest, however, that the assumption of HMO superiority cannot be applied to HMOs consisting primarily of Medicaid recipients. As Hester and Sussman noted in their review of the New York Medicaid experience:

Often advocates of prepayment give the impression that all that is necessary to establish an HMO is to assemble the staff, facilities, enrolled population, and dollars. Given these conditions, the "hidden hand" of economic incentives will guide the operation of the program in the desired way. This simply is not so.[4]

The Medicaid HMO distinguishes itself from other HMOs by the peculiar relationship that it has with the welfare bureaucracy. The Medicaid HMO survives and flourishes because it is able to satisfy administrators and muster political support. It need not be in compliance with regulations as long as it appears to be moving toward compliance. It need not provide specific services to clients as long as it appears to be delivering basic care. However, the HMO must maintain a constant and amiable relationship with the appropriate welfare offices, for the welfare bureaucracy grants approval, permits growth and negotiates a capitation rate.

* The benefit/cost ratio is a means for measuring how much of the premiums is returned to beneficiaries in the form of benefits (and how much is siphoned off for administrative costs and profits). The Medi-Cal study suggests an extremely low 48 percent benefit/cost ratio. Medicaid, Blue Cross, Blue Shield, and major commercial group policies usually have benefit/cost ratios well in excess of 90 percent.

Throughout this process, actual delivery of service to Medicaid patients is dependent primarily upon the bureaucracy's ability to monitor the HMO, and, secondly, upon the clients' ability to penetrate either the welfare department or the legislature. Unfortunately, monitoring an HMO is no small task. The elimination of the fee-for-service invoice makes it even more difficult because the HMO has very weak incentives to supply detailed utilization data to the welfare department. Such information represents a considerable cost. It is administratively difficult to collect. Further, it might prove needlessly embarrassing. In short, it pays the HMO not to submit utilization reports. The Michigan Department of Social Services for example, has been involved since 1971 with a particular HMO consisting almost entirely of Medicaid recipients. Six years after the initial contract the State had not received accurate or usable utilization data from the HMO. Despite the fact that the HMO had spent hundreds of thousands of dollars setting up a nonfunctional information system (and that the State as sole purchaser paid for that system) the Medicaid agency was unable to cajole, threaten or beg adequate utilization data from them. In part this was due to political pressure, in part to ineptitude in State administration and in part to the State's acceptance of the HMO's attitude. Nevertheless, the end result was that the State continued to reimburse this organization without a clear idea as to who was providing services and how, where, or why services were being provided.

The relationship between the Medicaid HMO and the Medicaid agency is similar to the relationship between a long term care facility and the Medicaid agency, particularly when the nursing home is paid on a flat rate basis (a fixed amount per day per recipient). Both the HMO and nursing home have agreed to provide a set of comprehensive services to a fixed population for a fixed rate per person. In both instances, the provider maximizes his revenues by minimizing the amount of services he provides. In each case, the State, not the client, is the critical monitoring source.

Unlike nursing homes, however, Medicaid HMOs experience a rapid level of disenrollment. Mobility, ineligibility determinations, voluntary disenrollment, all contribute to a continually high turnover in the enrolled population. In New York City, for example, it has been estimated that more than 36 percent of the Medicaid recipients enrolled in HMOs will have disenrolled within one year, more than twice the non-Medicaid rate. Not only does high enrollee turnover disrupt the HMO's budgeting and marketing process, it negates whatever long term benefits might be derived from preventive medicine. It encourages a short term perspective on the part of the HMO. This, in turn, has other detrimental implications.

If the prepaid group practice enters the market only in response to a short-term profit opportunity, it has little incentive to produce the amounts and quality of services which would attract future demand. Under these circumstances, it is rational for the plan owners to pursue short-term profits, and there can be no a priori assurance of adequate medical performance in the absence of direct regulation.[5]

Under the generalized HMO model, the non-Medicaid member's decision to join and remain within an HMO is a function of the member's financial contribution to his capitation payment, the cost and frequency of use of out-of-plan, non-covered services and perceived accessibility and quality. Within a Medicaid HMO, many of these forces become attenuated. The cost of the care is free. Administrative mismanagement and client confusion also produce frequent instances where enrollees receive free out-of-plan services. The perception of quality and access depend on what an individual is accustomed to and what his expectations are. This, in turn, is related to the patient's education, income and sophistication in successfully confronting institutional barriers. In all three areas, the Medicaid recipient ranks lower than his non-Medicaid counterpart. In particular, the type of docile behavior encouraged by the welfare agency in its dealings with clients would produce HMO members least likely to register a grievance or "alter" an HMO's performance.

HMOs developed as a joint political and organizational alternative to fee-for-service. They were often uncritically integrated into the Medicaid program. Shortly thereafter, it became clear that the behavior of HMOs specializing in Medicaid clients differed significantly from behavior predicted by theory and the experience of established HMOs. States have reevaluated their approach to this alternative. Although caution is advisable, HMOs should not be eliminated as a Medicaid option. The use of HMOs in a welfare program, however, requires that States carefully monitor HMO marketing practices, delivery of services and disenrollment. In the absence of that monitoring, HMOs may prove to be an alternative that is more costly and less effective than fee-for-service.

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VII. MEDICAID AND NATIONAL HEALTH INSURANCE

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NATIONAL HEALTH POLICY:
LESSONS FROM THE
MEDICAID JUNGLE

Many people in Washington who are examining National Health Insurance believe that the States are unwilling to finance and are incapable of administering a large-scale health program. If we don't agree with that outrageous statement, then I think we have to see if the problems with Medicaid do, in fact, lie elsewhere than with State unwillingness and incapacity. Have we learned, perhaps, that the basic concept of Medicaid was flawed, that the Federal policy leadership might have been less than firm and precise? Or, perhaps, we've learned that the problems arise from the implementation of the concept with an administrative jungle of adversary relationships that preclude effective management. I'd like to examine the concept and the implementation and see what lessons there are for national health insurance, and then discuss some of the policy issues.

The Medicaid program is a poor program for poor people. This basic flaw in concept will not be changed until some form of national health program is enacted that treats all persons equally. For those of us who would place the values of equality and equity above and before the libertarian values of economic efficiency, then the Medicaid concepts of welfare medicine, means test eligibility, limited benefits, variable by geographic area and income levels, client-oriented controls and the like are anathema and should be changed as soon as possible. If the basic values and concepts are flawed, then the results they produce and the way they produce those results cannot be a model for national health insurance. Clearly, Medicaid cannot be a model.

Yet the issues in guaranteeing care for the population as a whole are much the same as those with which the Medicaid and Medicare programs have been struggling for ten years! The basic objectives of Medicare and Medicaid were to make certain that eligible persons -- the indigent, the medically indigent and the elderly -- received adequate care and were relieved of the financial burden involved. However, Medicare and Medicaid highlight all the inequities of financing programs that deal with a limited population segment and reside in an imperfect private market.

Inadequate financial coverage under Medicare, for example, has meant significant out-of-pocket expenditures for the elderly. Medicare pays only 40 percent of the health care expenditures for

the aged beneficiaries, and the aged today are paying more out of their own pocket for medical care than they did in 1965. Unless a ceiling is placed on the person's financial liability, the goal of eliminating financial burdens will not be achieved. State variability in benefits and coverage under Medicaid is one of its major problems, but, even within States that have had fairly liberal programs, the inequities of means test medicine, low practitioner fees, and resulting low levels of provider participation, the escalating cost and the generally poor public image of the program, are visible indicators of failure.

More pertinent, the major expenditures under these programs have supported the traditional health care delivery system and helped to institutionalize and perpetuate the irrationality of many practices, for example, increasing specialization, emphasis on institutional care, emphasis on fee-for-service practice and fragmentation of patient care. Studies have demonstrated that these programs, particularly Medicaid, have made little change in the source, frequency or purpose of medical care. Poor families are still more likely to receive less care relative to need, to depend more on public clinics, and to have a higher level of illness-related, rather than preventive, medical contact. In effect, Medicaid has solidified the dual system of health care, one system for the poor and another for the more affluent.

Medicare and Medicaid have shown that investment in the expenditure side, without complementary adjustments in resource supply, will result in inflation in medical care costs. It should be enough to note that the \$140 billion we are now spending on medical care -- personal health care services -- in this country is more than most nations have as their total gross national product. Only seven nations in the world have a gross national product greater than \$140 billion.

The Medicaid experience should teach us that in making our choices for national health insurance, we cannot and should not have one program of benefits and administration for the poor and another for the more affluent. We know that this will not be equitable, that we cannot control the system or reform it. We cannot and should not try to administer a means-tested eligibility system. It is not only demeaning and dehumanizing, but it is also very, very expensive. A study done in California, for example, showed that the administrative costs were \$200 per person per year to find a person eligible for the medically-needy program! What we should learn from Medicaid and its flawed concept is that we need and should enact a national program of comprehensive benefits for everyone in the nation, with controls on the providers, not the clients, with limitations on expenditures, nationally and locally, and with reform of the delivery system. This would be the most

equitable as well as most efficient and economical to administer.

A flawed concept, I think, necessarily implies flawed implementation as we have seen. While the blame has largely been placed on the States, the problem is really much more complex and has serious implications for national health insurance. I speak of the current fundamental problems of the adversary relationships that exist generally in society, that seem to be exacerbated in the health care system. It's a phenomenon that some observers refer to as a general loss of civitas in our society -- loss of a spontaneous willingness to obey the law. The fraud and abuse in the Medicaid program is a prime example. In our general anger toward the poor who are on welfare, are we failing to respect the rights of others and are we unwilling to forego private wants for public needs? Are we unwilling to consider compromises between our private organizational interests and public needs? The hospitals, for example, are fighting tooth and nail against cost control measures. All of these phenomena tend to create adversary relationships that make administration of programs similar to Medicaid difficult, if not impossible, to regulate. Without widespread voluntary compliance with regulations, we cannot regulate, because enforcement, if not impossible, is extremely expensive.

In the governmental sector, particularly in Medicaid, we have seen the adversarial postures in relationships between the executive, legislative and judicial branches at a level more pronounced than might commonly be expected. However, the adversarial relationships between levels of government and between the public and private sectors are most important to Medicaid administration. The services of the Medicaid program, perhaps, constitute an excellent example of the nature and effects of these adversary relationships. In some instances, Medicaid has created such relationships. In other instances, it has made them worse. And, in still others, it has been simply an innocent bystander bearing the brunt of the burden.

Solving the problems of intergovernmental relationships is reportedly a high priority of the Carter Administration and not simply in terms of fiscal relief, but in restructuring incentives and overcoming the adversary relationships which have been prevalent. What we have seen is a tremendous growth in Federal grants to States and localities from less than \$1 billion in 1945 to more than \$70 billion in 1977. That \$70 billion constitutes one-fourth of the Federal domestic budget and contributes one-fourth of total State and local revenues. The largest single block of Federal grants to States is in public welfare, including Medicaid. The States have had an incentive to maximize the Federal dollar, and correspondingly to minimize the State dollar, sometimes disregarding actual needs and frequently skewing program

objectives. In reaction, the Federal government now attempts to regulate State welfare programs almost as if they were public utilities. The Federal government prescribes rules for State entry into public welfare programs: rules for the quality of their performance, standards that affect their expenditures and detailed processes of management of the programs. Gone are the old days of the Federal pass-through or even the touted Federal-State partnership. In its place is the Federal Register and the Code of Federal Regulations.

Clearly, Federal regulation of the States has evolved in the past ten years in part as the result of the adversary relationship between Congress and the Executive branch, with the former developing, not more precise statements of policy and intent, but increasingly more detailed and prescriptive statutory requirements. In addition, particularly in welfare programs, major concerns arise with respect to expenditures when there is no closed end on the Federal purse, with respect to inequities between States and with respect to apparent poor State management performance. Thus, attempts are made to regulate the State programs by limiting the Federal contribution, by mandating standardization and uniformity and by providing both sanctions and penalties to improve performance. Unfortunately, it is only conjecture as to what are realistic norms of performance in a program like Medicaid. Therefore, to achieve expenditure control, standardization and uniformity and better management, Federal regulation is forced to concentrate on the process of carrying out the program, not the product or outcome.

What has been the effect of this kind of process-oriented regulation of the State? First, sanctions and penalties clearly have moved State programs along in some instances: the "stick", if nothing else, gets attention. And, the threat that penalties will be applied has stimulated action. Yet the regulations and their enforcement have created tremendous ill-will between the States and at least the Regional Offices of HEW, if not also the Central Office. State staff will not openly share information about the program with Regional Office staff for fear that it will be used against them in audits, sanction reports, and penalty citations. HEW staff that should be available for technical assistance are used for audits and lose their effectiveness. Inequities in enforcement among regions are blatant.

Contradictions occur that are difficult to resolve. In most of Medicaid, the problem seems to be how to curb overutilization that is presumed to be rampant. In a program like Early and Periodic Screening Diagnosis and Treatment (EPSDT), the focus of concern is underutilization. One wonders: if there are really grounds to assume that overuse and abuse of the system, generally, by clients, does, in fact, exist?

What are the implications for national health insurance if this kind of adversary relationship developed as part of the administrative process in Medicaid? Presumably the States might play a more or less important role in national health insurance, ranging from the kind of role currently undertaken in Medicare, to possible broader responsibilities deriving from the National Health Planning and Resource Development Act. However, irrespective of the role, two main implications can be drawn. First, the current adversary atmosphere exists, in large part, because of the nature and structure of the decentralized management control process. Presumably, under national health insurance, there will be major decentralization of management functions, whether to the States, to private agents, to regional structures, or to decentralized offices of a Federal agency. Therefore, if centralized management control of decentralized implementation is to be effective, it must focus on performance, not process, and must structure the communication processes, management performance standards and incentives, in order to maximize agreement on ends as well as means. We must learn from Medicaid and from Medicare what does and does not work in that kind of a communications process. Secondly, national health insurance policy-makers and administrators should accept that in a heterogeneous nation, variation is not only acceptable, but desirable. Provided that inequities are removed and minimums are met, uniformity and standardization need not be absolute and inflexible goals.

Perhaps the most crucial area that apparently has become highly adversarial is that between the private and the public sectors. We see rising unit prices and costs of private providers of service; evidence of increasing incomes of practitioners; increasing, uncontrolled revenues to hospitals and nursing homes; and escalating publicity on the fraud and abuse in both public and private programs. Then we have the public sector responding with what I like to term the "control-of-the-month" -- HMOs, HSAs, PSROs, prospective reimbursement fee schedules, second opinion surgical consultations, certificates of need, prior authorization, fee screens, hospital rate reviews and on. As soon as a new control is drafted, someone brings a lawsuit and we're back in court. The adversary relationship is rampant, no one trusts anyone, and Medicaid has done its share to extend the problem. However, Medicaid has tried, but found that it cannot regulate the system effectively when it deals with only 10 percent of the population and that population is poor. Unfortunately, in learning that lesson, it has driven providers away from serving its population and, consequently, has not served its clients well. Provider participation is a major problem in most States, with providers vying for reasons to give for non-participation. The reasons include fees, too much paperwork, over-regulation, and assertions that "these people won't keep appointments, won't follow orders."

Without dwelling on the examples of the adversary relationship created between the public and private sectors, I think the issues for a national health policy and implementation are obvious. Unless we can forge some better partnerships, unless we can learn how to balance regulation and competition, unless we learn to trust "them" and "they" learn to trust "us", we will not be able to implement national health insurance.

Trade-offs between the equity to be achieved through public accountability and the efficiency attributed to the private sector will be needed and will be made. Within these trade-offs, some attention must be placed upon the irrational and fragmented nature of the methods we are using to regulate. Simplification, consolidation, congruence are essential. How long can we live with the PSRO, battling over data with the HSA, which was trying to prevent the building of a hospital for the HMO, which in turn, is fighting the rate review commission, which is in a turf battle with the State health planning and development agency, which is under pressure from the State nursing home licensing agency to do something about the new State Medicaid policy related to Medicare. Surely, no national legislative process created that system. Surely, no rational bureaucrat would perpetuate it.

I don't believe I've exaggerated the situation, its pervasiveness, nor its seriousness. Adversary relationships do now exist. I'm concerned because I think these adversary relationships, if they are allowed to continue, will create barriers to any effective implementation of national health insurance when it is enacted. However, none of the conditions I have described are irreconcilable or irreversible. No doubt, they will be very difficult to reverse, even with dedicated leadership. Nonetheless, we must take steps to assure that (1) executive and legislative branches work together, not only to define reasonable policy and enforceable laws, but also to develop programs capable of being implemented; (2) inappropriate lawsuits do not inundate the courts when arbitration would be a more appropriate remedy; (3) decentralized management control techniques offering appropriate incentives to meet defined performance objectives are structured; and, (4) new, more rational and interrelated regulatory models are developed in partnership with the public and private sectors.

I would like to conclude with some thoughts on how to move from Medicaid to national health insurance and some of the major issues that will be under consideration in national health insurance. Assuming that

- Mr. Carter keeps his campaign pledge to propose a national health program which will have comprehensive benefits, mandatory and universal coverage combined with public financing and with a role for the private sector;
- Mr. Carter will keep his pledge to put that proposal before the Congress early next year; and assuming that there are at least four committees of Congress that will hold hearings on the proposal and report out bills;
- a conference between the two houses will result in some agreement between the two houses, and
- the President has taken an active role in pushing for the legislation,

it is possible that there may be a national health insurance bill signed into law before the next presidential election.

Hopefully, the law will permit at least a two-year lead-time for implementation. Conceivably, the earliest that Medicaid would be replaced, or modified, or retained would be 1982. Beyond the improvement of Medicaid and the potential that you have for showing how to do it, it seems to me that you in the State legislatures are in a unique position to move more rapidly than the Federal level to bring about some changes in the delivery system.

Effective control of total health care expenditures needs attention within the total system. Some States are now developing public utility models for health care, controlling capital expenditures, supply, institutional rates, and improving competition between HMOs and other kinds of organized delivery systems. These will be some of the more effective ways of keeping the rate of increase in Medicaid expenditures down, as well as in the rest of the system. You cannot change the system only with Medicaid, nor can you at the State level reverse the problems of inflation, unemployment, and long term care which are some of the major problems in Medicaid expenditure increases. These demand national solutions. So, presumably, you will also be active in trying to influence the national scene? What is your position in the States on the role of States under national health insurance? This probably will be one of the key decisions on national health insurance policy.

Do all the States actually agree on the goals they want from national health insurance? Equity versus efficiency, public versus private sector roles? Where are you on a health security plan versus a mandated private health insurance plan? Are you knowledgeable about the various options that will affect your future roles, the States' future roles in the health sector? At one end of the spectrum are the plans that would nibble away at the margin or fiddle away at the fringes with small incremental changes offering protection only to small segments of the population. At the other extreme are proposals for a national health service which would incorporate financing from general revenues, physicians in group practices employed by the Federal government, publicly-owned hospitals, administration through Federal, State and local agencies. In between these extremes, lie a wide spectrum of specific proposals, none of which will be enacted as currently drafted.

There will be four major areas of debate. First, the role of the private sector, particularly the private health insurance industry, concerning administration, potential financing or underwriting will be discussed. This is related to the amount of money that can go directly on to the Federal budget. The second major issue will be the role of the States -- in program financing and in administering. A third major area of concern will be phasing and timing: what benefits will be phased in, when, and for how long. Will there be phasing in and/or phasing out of cost sharing later on, and how long will we take on some of these phases? And finally, we must consider the structure of controls and incentives in the system. Are we going to try to impose controls on the demand side, on the client side, or are we going to emphasize controls on the provider side? I would assume that you will become more active in lobbying at the national scene on some of these issues.

I'd like to just conclude with a philosophical note. I don't think we question any longer that the public sector plays the pivotal and dominant role in our economy. Nor can we deny that individual demands for equal rights mean rising expectations for basic entitlements to income, health care, housing, as well as education. While society must achieve the appropriate trade-off, between economic growth and income distribution, it must do so with equity, giving everyone a sense of fairness and assuring that people actually become more equal so they can be treated equally.

OVERVIEW

It appears that the American medical care system will require significant change under any foreseeable form of national health insurance (NHI). Indeed, the medical care system is so central to every issue now pressuring government to intervene in health care, that significant change appears unavoidable even in the absence of NHI. Therefore in asking what kind of NHI we want, Americans must begin asking what kind of future medical care system we want: they are the same question. This paper examines the forces compelling change and the major options open to us. The principal points are summarized below:

- Americans increasingly believe that medical care use should be determined not by income and personal circumstance but by some standard of need. Medicare and Medicaid and the growing interest in NHI are expressions of this belief. The dilemma is that we already know how to practice a style of medicine in the United States which, if extended equally to all, would be far more expensive than this nation would or should pay.
- The ability of American medicine and technology to elaborate this style is almost endless: the medical care system can legitimately absorb every dollar society will make available to it. Already this costly elaboration is occurring under Medicare, Medicaid and comprehensive private insurance to such an extent that government has felt compelled to intervene more and more strongly in the medical care system. Despite this intervention, medical care expenditures have risen more than 300 percent in the last ten years with little detectable improvement in the nation's health.
- This cost escalation is unlikely to abate. It is deeply rooted in the structure and incentives of the present medical care system and its financing. Considering that present health insurance artificially lowers the price to the consumer and provides a virtual blank check to the medical care system, which has every professional, financial, legal and ethical incentive to do more, it seems doubtful that costs can be acceptably contained short of significant change in the present system.

(As one example, in the next few years the United States could spend \$20 billion on just one new procedure, coronary bypass surgery, alone. If one had \$20 billion to spend on the health and well-being of the United States, would he spend it on a single procedure, particularly on one whose range of efficacy is not yet established? Would he even spend it on medical care alone, given that non-medical interventions -- nutrition, environment, safety -- have equal or greater impact on health? The point is that under the present system there is no choice: present health insurance commits us to buy whatever the medical care system chooses to do. This example can be endlessly multiplied.)

- Thus health care is no longer a benign issue. Medical cost escalation is already placing severe strain on public and private budgets, increasingly impinging on our ability to finance other equally important national priorities. Should NHI force us to overspend for medical care, the health and well-being of the nation could actually be reduced. Eventually, the nation will be forced to do everything and anything necessary to contain medical costs.
- Present research and experience suggest three basic approaches that might contain costs: (1) increased consumer cost-sharing (higher deductibles and coinsurance, but with some maximum limit on what the consumer must pay) to make consumers more cost-conscious; (2) more prepaid alternative delivery systems (such as HMOs, etc.) which strongly alter provider incentives; and (3) extremely strong public utility regulation (most likely requiring the power to fix total expenditures in advance). An effective NHI program will combine one or more of these approaches. (But whatever combination of approaches is chosen, it must be built into NHI as a central feature; effective cost containment is too complex to be tacked on.)
- Each of the three approaches above exerts significant but different changes in the medical care system and its financing. But presently there is little awareness or consensus for change of this magnitude by either the public or providers. Consequently, effective cost containment strategies will be politically long and difficult to implement, whereas ineffectual strategies will be easy (and very expensive) to fall into.
- To learn what works and to build consensus, public debate and incremental action on some consistent combination of the three potentially effective approaches should begin now, well in advance of NHI. The debate should focus on

what future medical care system we want and in which directions proposed incremental actions are likely to lead us. Immediate incremental actions should be designed to learn more about all three approaches in mutually consistent ways which do not foreclose the available options. Such actions might include making existing cost-sharing more simple, more strongly encouraging alternative delivery systems, and focusing on regulation presaging an eventual "lid" on total expenditures.

FINDINGS AND CONCLUSIONS

The Problem: National health insurance may seriously aggravate medical care cost escalation and maldistribution. Even without NHI, medical cost escalation makes government action virtually inescapable.

1. As we learned from Medicare and Medicaid and the continuing spread of comprehensive private health insurance, present health insurance -- whether public or private -- is one of the principal causes of serious cost escalation. Present health insurance artificially lowers the price to the consumer, gives a blank check to the provider, and leaves payment in the hands of a weak third party, the insurer, in no position to control either the use or cost of services. As a result, normal market mechanisms for cost constraint and efficiency are destroyed.
2. The other principal cause of cost escalation is the nature of medical care and the structure and incentives in the medical care system itself. The medical care system can legitimately absorb every dollar society will make available to it, and has every incentive to do so. The style and standards of medical care are indefinitely expansible. By more and more elaborate diagnostic tests and therapeutic procedures, providers can always try to provide greater safety margins for treatable patients and try to treat more and more hopeless cases. Technology is continually expanding these possibilities. Moreover, the professional and financial incentives on providers in the present medical care system are powerfully skewed toward high cost, highly technological care. Professional challenge, reputation and income all increase with increasing specialization and more elaborate levels of care, giving rise to a kind of medical Parkinson's law: standards of practice rise to absorb the dollars available.

3. This combination of factors -- health insurance removing the cost constraint from providers with powerful incentives for high cost care* -- has produced a large, poorly distributed, inefficient medical care system with chronic cost escalation out of all proportion to any real or expected gains in health. The cost escalation is predominantly demand-pull rather than cost-push. Costs do not push up prices; rather, insurance allows prices to be raised and providers put the dollars into higher cost activities. Contrary to popular expectation, aside from certain underserved subgroups there is little indication that more medical care will make measurable improvement in the nation's health. Overall we appear to be beyond the point of diminishing marginal returns, where very large expenditures are needed to make even small gains for a few additional people. Improvement in health levels is more likely from improvement in nutrition, lifestyle and environment than from further investments in medical care.
4. Even without NHI, medical cost escalation is now so chronic and severe, its pressure on public and private budgets so great, that government action appears unavoidable; NHI will hasten such action. In just ten years, medical expenditures have risen from 5.9% to 8.3% of GNP. So drastic a rate of cost escalation in so large an industry (which NHI would compound) not only constitutes significant inflationary pressure on the economy generally, but places extreme pressure on public budgets, which pay 40% of the bill. Just the annual increase in Medicare and Medicaid alone -- \$5 billion dollars and growing -- will shortly exceed the cost of all other HEW health programs combined, increasingly impinging on our ability to finance other equally important national priorities. Even if some combination of public and private financing sources for NHI could be found today, at current rates of medical cost escalation we must be prepared to see the burden on those sources double in less than eight years. Thus without effective action, the medical care system, especially under NHI, threatens to become a vast vacuum cleaner, sucking up uncontrollable amounts of GNP and scarce tax dollars for medical care.

* It should be emphasized that the problem is structural, not conspiratorial. When someone else pays, providers try to do too much and patients want the best, including comfort and convenience, regardless of cost or potential effectiveness. The system is therefore misbehaving exactly the way society rewards it to misbehave.

Basic Options: It is doubtful that medical costs can be acceptably contained short of significant change in the present medical care system and its financing. Any effective cost containment strategy must consider what kind of future medical care system Americans want.

1. Cost escalation will not yield to quick band-aid solutions. Effective strategies must intervene and alter the deeply rooted incentives in the present system of medical care and health insurance described above. We already know how to practice a style of medicine in this country which, if extended equally to all, would cost more than the nation would or should pay. We shall have to actively discourage aggressive, elaborate (high) styles of practice, and encourage equally effective but more conservative and efficient (low) styles. High style care is not necessarily bad or unnecessary; indications for medical intervention are so imprecise that acceptable styles of practice can vary 100% in per capita utilization. It is simply cost ineffective, i.e., we accomplish more health spending our money in other ways. Therefore, high style will not be curtailed by controls simply aimed at bad or unnecessary care, no matter how powerful. It will be curtailed by strategies altering or countering incentives in the present system supporting high styles.
2. There are three major options which present research and experience suggest might contain cost. Each has quite different impacts on the present system of medical care and health insurance. All will be politically difficult to implement. The three options correspond to the three parties with power to control cost and use of services, who could replace the weak third party payer: respectively (1) the consumer, (2) the provider, and (3) the government. The first two approaches anticipate less government involvement ("consumer market oriented"); the third anticipates increased government involvement ("public utility oriented"). An effective cost strategy will combine one or more of these options.
 - Consumer cost-sharing: Presently if the consumer is fully insured, he has no incentive to be an efficient user of care. This approach would use large coinsurance and deductibles to induce the consumer to use care more prudently. (Financial protection can still be assured by limiting the consumer's cost-share to some maximum amount. Bias against the poor can be avoided if the cost-share is income-related). This approach entails the least change in the medical care

system, but other controls will be necessary for catastrophic care above the consumer's maximum cost-share limit. However, cost sharing of the magnitude necessary to work effectively involves taking away existing benefits, which is extremely difficult politically.

- **Provider Incentives:** Providers are presently rewarded for cost-raising behavior. This approach would reorganize the private medical care system so that it has improved structure and incentives for cost-effective performance; the encouragement of HMOs and other prepaid alternative delivery systems are examples. However, considerable private initiative will be needed to create sufficient change to influence the behavior of the entire medical care system. Encouraging the necessary motivation and acceptance will be difficult. (Incentive reimbursement of fee-for-service providers may also be possible, but this verges more toward the regulatory approach below since it must be compulsory to work.)
- **Public Utility Regulation:** Public cost controls are presently limited to Medicare and Medicaid, which simply squeezes the old and the poor rather than the medical care system. This approach would place public utility controls on the medical care system, with price, entry and quality controlled by regulation. However, experience in other regulated industries and other countries suggests the controls must be extremely powerful and carefully designed to work well, most probably requiring that government have the power to fix the budget for regulated services in advance. Regulatory intervention is the simplest approach to implement incrementally, but controls of the magnitude to work effectively will require substantial change in the medical care system, and will be a long difficult course politically.

Six Illustrative NHI Models and Their Prospects: Taking considerable liberty, existing NHI proposals fall roughly into the following models. Because they demand change, effective NHI models will be politically difficult to implement, whereas expensive ineffectual models are politically easy to fall into.

1. Two Models Likely to Fail

Model 1 - The Present Medical Care System with Universal Third Party Coverage. This model would leave the present medical care system unchanged and simply extend

comprehensive third party reimbursement insurance to all. Because it leaves existing institutions alone, it would attract considerable initial political support. But, as noted earlier, this model will severely aggravate cost escalation. It is therefore unstable; runaway cost will force intervention, probably in the form of ever increasing regulation, and the nation will eventually move at great expense to a more successful model.

Model 2 - Piecemeal Public Utility Controls with Universal Third Party Coverage. This model establishes public utility controls on the separate pieces of the cost equation: price and fee controls, utilization controls, facilities controls, etc. The model will likely fail, even with quite strong controls. As Phase III showed, even if prices and fees are well controlled, total costs go up because providers can always increase the quantity and mix of services toward higher style. But (besides difficulties of sheer volume and the ill-defined nature of services) control of service quantity and mix requires medical judgment, an impossible conflict of interest. All regulated industries risk capture by the regulated; this approach virtually demands it. Nevertheless, because regulation can be incrementally implemented, this model will be politically popular. The danger is that as costs continue to escalate, the medical care system will be immobilized under ever increasing, expensive but ineffectual controls difficult to dismantle when the nation finally tries to move on to a more successful approach.

2. Four Models That Might Work

Model 3 - Universal Major Risk Insurance (MRI). This model emphasizes consumer cost sharing. The consumer is totally insured, but only for medical expense in excess of 10% of his income. (The plan could be even more strongly income related if desired). Thus while totally protected financially, consumers would pay most medical bills out-of-pocket, placing powerful market pressure on consumers to use care prudently and, thereby, on providers to hold cost. This approach would have to be supplemented with strong controls on catastrophic care. However, the great majority of people now have basic benefits below the income-related deductible of MRI, vitiating MRI's cost-sharing approach. These benefits would probably have to be legislated away under an MRI approach, politically impossible at present.

Model 4 - Prepaid Alternative Delivery Systems with Universal Coverage. This model emphasizes provider incentives, and is based on the fact that HMOs and other prepaid comprehensive care organizations reverse the present incentives on providers and reward cost-effective performance. This model would stimulate a pluralistic private system with consumers choosing among prepaid alternative delivery systems and traditional provider insurance plans on the basis of price, benefits and service. Consumers would have an income-related subsidy or voucher to assist purchase of an adequately comprehensive plan. However, while the medical care system remains private and government regulation minimal, there must be a large number of the new prepaid alternative systems sufficient to impact traditional provider behavior. Prepaid delivery systems can be stimulated incrementally, but encouraging the necessary private initiative and acceptance for the large number of new systems needed will be politically difficult.

Model 5 - Public Utility Allocation Model (Akin to British Approach). This model converts the entire medical care system into a public utility with a fixed budget. Consumers have comprehensive coverage. The budget could be allocated to providers directly or, alternatively, by incentive reimbursements retroactively adjusted to stay within the budget. Strong regulatory controls on manpower, facilities and services are also required to assure the budget is not exceeded. Unlike piecemeal public utility controls, which use medical judgment to determine costs, this approach specifies overall budget in advance and uses medical judgment to allocate within this fixed amount. However, while regulations can be implemented incrementally, public intervention of the magnitude required for this model is unprecedented.

Model 6 - Public Utility Hospital Model. This model converts just the hospital sector into a public utility (rather than the entire system as in the previous model), placing both hospital services and inpatient physician services under a fixed overall budget. Strong regulatory controls on hospital size, service mix, staff and manpower are required to assure that the budget is not exceeded. Consumers have comprehensive coverage, with ambulatory care costs contained by strong, income-related cost-sharing. Because the regulatory controls can be implemented incrementally and are less demanding (but also less certain to work) than in the previous model, this model may have the best eventual political chances. Neverthe-

less, this model requires exceedingly strong public intervention and control, which will be politically long and difficult to achieve.

3. Further models combining all three approaches -- consumer cost-sharing, provider incentives, and public utility controls with a fixed budget -- seem possible and may be more attractive technically and politically, but further study is needed. Consumer market approaches may help take some of the cost containment and political pressure off public utility regulation, and vice versa. But additional study is needed to assure that such different approaches complement rather than defeat each other.

RECOMMENDATIONS

1. NHI plans should be built around a credible cost containment strategy. Effective cost containment must be central to any NHI plan; it cannot be tacked on. Decisions on eligibility, benefits, financing and administration, as well as how fast to stage the plan, cannot be made before a cost containment strategy is arrived at. Otherwise, they will defeat rather than complement the cost containment strategy.
2. The necessity for change, and what the choices are, should be made widely known by public debate. If the public and providers are to support needed change, more widespread understanding is needed that the provision of adequate health care and health insurance protection to all at a cost the nation can afford will require significant change in the American medical care system and its financing. The kind of medical care system we want under NHI -- consumer market oriented, public utility oriented, or a combination of both -- should be given informed, searching public debate.
3. Public debate should also focus on what immediate actions should be taken now, well in advance of NHI, on each of the three major cost-containment approaches so that we move toward the future system we want. Such actions should be designed to learn what combination of approaches works and is acceptable, and should not foreclose the available choices. Possible actions include:
 - Existing cost-sharing might be made more uniform, simple and understandable, and consumers might be better informed of their choices, through "truth in health insurance" legislation.

- Prepaid alternative delivery systems might be more strongly encouraged through improved assistance legislation and Medicare and Medicaid reimbursement.
- Public utility regulation might focus on development of compulsory incentive reimbursement mechanisms presaging an eventual fixed budget approach, but in ways which do not discourage cost-sharing or prepaid alternative systems.

Appendix A - GLOSSARY OF BASIC MEDICAID TERMS

The following definitions have been excerpted from "A Discursive Dictionary of Health Care" prepared by the staff of the Subcommittee on Health and the Environment, the Committee on Interstate and Foreign Commerce, House of Representatives

Abuse: improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur, intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition; when cheaper treatment would be as effective; or when billing or charging does not conform to requirements. It should be distinguished from fraud, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or to claim program eligibility. Abuse is not necessarily either intentional or illegal.

Actual Charge: the amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual charge may differ from the customary, prevailing, and/or reasonable charges under Medicare and other insurance programs.

Allied Health Personnel: specially trained and licensed (when necessary) health workers other than physicians, dentists, podiatrists and nurses. The term has no constant or agreed upon detailed meaning: sometimes being used synonymously with paramedical personnel; sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician; and sometimes referring to health workers who do not usually engage in independent practice.

Ambulatory Care: all types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his home to receive services and has departed the same day.

Assignment: an agreement in which a patient assigns to another party, usually a provider, the right to receive payment from a third-party for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In Medicare, if a physician accepts assignment from the patient, he/she must agree to accept the program payment as payment in full (except for specific coinsurance, copayment and deductible amounts required of the patient). Assignment, then, protects the patient against liability for charges which the Medicare program will not recognize as reasonable. Under some national health insurance proposals physicians must agree to assignment for all of their patients or none of them; under Medicare, physicians may choose assignment for some of their patients but not others, and may do so on a claim by claim basis for some services but not others.

Carrier: a commercial health insurer, a government agency, or a Blue Cross or Blue Shield plan which underwrites or administers programs that pay for health services. Under the Medicare Part B (Supplemental Medical Insurance) Program and the Federal Employees Health Benefits Program, carriers are agencies and organizations with which the program contracts for administration of various functions, including payment of claims. See also intermediary and third party payer.

Categorically Needy: persons who are both members of certain categories of groups eligible to receive public assistance, and economically needy. As used in Medicaid, this means a person who is aged, blind, disabled, or a member of a family with children under 18 (or 21, if in school) where one parent is absent, incapacitated or unemployed and, in addition, meets specified income and resources requirements which vary by State. In general, categorically needy individuals are persons receiving cash assistance under the AFDC or SSI programs. A State must cover all recipients of AFDC payments under Medicaid; however, it is provided certain options (based, in large measure, on its coverage levels under the old Federal/State welfare programs) in determining the extent of coverage for persons receiving Federal SSI and/or State supplementary SSI payments. In addition, a State may cover additional specified groups, such as foster children, as categorically needy. A State may restrict its Medicaid coverage to this group or may cover additional persons who meet the categorical requirements as medically needy.

Coinsurance: a cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage (usually 80 percent) of all or certain specified covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remaining percentage of the costs., until the maximum amount payable under the insurance policy, if any, is reached.

Copayment: a type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time (e.g., \$2 per visit, \$10 per inpatient hospital day), their insurer paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike coinsurance, which is payment of some percentage of the cost).

Cost-Related or Cost-Based Reimbursement: one method of payment of medical care programs by third parties, typically Blue Cross plans or government agencies, for services delivered to patients. In cost-related systems, the amount of the payment is based on

the costs to the provider of delivering the service. The actual payment may be based on any one of several different formulae, such as full cost, full cost plus and additional percentage, allowable costs, or a fraction of costs. Other reimbursement schemes are based on the charges for the services delivered, or on budgeted or anticipated costs for a future time period (prospective reimbursement). Medicare, Medicaid and some Blue Cross plans reimburse hospitals on the basis of costs; most private insurance plans pay charges.

Customary Charge: generally, the amount which a physician normally or usually charges the majority of his patients. Under Medicare, it is the median charge used by a particular physician for a specified type of service during the calendar year preceding the fiscal year in which a claim is processed. There is therefore, an average delay of a year and a half in recognizing any increase in actual charges. Customary charges in addition to actual and prevailing charges are taken into account in determining reasonable charges under Medicare.

Deductible: the amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g. \$100 per calendar year., benefit period, or spell of illness. Deductibles in existing policies are generally of two types: (1) static deductibles which are fixed dollar amounts, and (2) dynamic deductibles which are adjusted from time to time to reflect increasing medical prices. A third type of deductible is proposed in some national health insurance plans: a sliding scale deductible, in which the deductible is related to income increases.

Early and Periodic Screening ·Diagnosis and Treatment Program (EPSDT): a program mandated by law as part of the Medicaid program. The law (section 1905 (a)(4)(B) of the Social Security Act) requires that by July 1, 1969, all States have in effect a program for eligible children under age 21 "to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary." Issuance of regulations implementing the program was delayed until November, 1971, and States were allowed to phase in their programs by age groups until July 1, 1973. By law (section 403 (g) of the Social Security Act), States which do not have a program in effect in any fiscal quarter after June 30, 1974, for all children in families receiving AFDC payments are

subject to a financial penalty.

Fee for Service: method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee for service payment system, expenditures increase not only if the fees themselves increase but also if more units of service are charged for, or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or prepayment systems, where the payment is not changed with the number of services actually used or if none are used. While the fee-for-service system is now generally limited to physicians, dentists, podiatrists and optometrists, a number of other practitioners, such as physician assistants, have sought reimbursement on a fee for service basis.

First-Dollar Coverage: coverage under an insurance policy which begins with the first dollar of expense incurred by the insured for the covered benefits. Such coverage, therefore, has no deductibles although it may have copayments or coinsurance.

Fiscal Agent or Intermediary: a contractor that processes and pays provider claims on behalf of a State Medicaid agency. Fiscal agents are rarely at risk, but rather serve as an administrative unit for the State, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors. Medicaid fiscal agents are sometimes also Medicare carriers or intermediaries.

Fraud: intentional misrepresentation by either providers or consumers to obtain services, obtain payment for services, or claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven. See also abuse.

Generic Name: the established, official, or non-proprietary, name by which a drug is known as an isolated substance, irrespective of its manufacturer. Each drug is licensed under a generic name and also may be given a brand name by its manufacturer. There have been recent attempts to encourage physicians to prescribe drugs by generic names whenever possible instead of by brand names. This is said to allow considerable cost savings.

Health Maintenance Organization (HMO): an entity with four essential attributes:

(1) an organized system for providing health care in a geographic area, which entity accepts the responsibility to provide or otherwise assure the delivery of

(2) an agreed upon set of basic and supplemental health maintenance and treatment services to

(3) a voluntarily enrolled group of persons, and

(4) for which services the HMO is reimbursed through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided.

Intermediary: a public or private agency or organization selected by providers of health care which enters into an agreement with the Secretary of HEW under the Hospital Insurance Program (Part A) of Medicare, to pay claims and perform other functions for the Secretary with respect to such providers. Usually, but not necessarily a Blue Cross plan or private insurance company. See also carrier and fiscal agent.

Intermediate Care Facility (ICF): an institution recognized under the Medicaid program which is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulation and coverage than institutions which do not provide health-related care and services. An ICF/MR is an ICF which cares solely or particularly for the mentally retarded.

Long Term Care: health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long term basis. The term is often used more narrowly to refer only to long term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services, like home health care, which also can be provided on a long term basis, are seen as alternatives to long term institutional care.

Management Information System: a system (frequently automated or computer based) which produces the necessary information in proper form and at appropriate intervals for the management of a program or other activity. The system should measure program progress toward objectives and report costs and problems needing attention. Special efforts have been made in the Medicaid program to develop information systems for each State program.

Medicaid Mill: a health program which serves, solely or primarily, information Medicaid beneficiaries, typically on an ambulatory basis. The mills originated in the ghettos of New York City and are still found primarily in urban slums with few other medical services. They are usually organized on a for profit basis, characterized by their great productivity, and frequently accused of a variety of abuses (such as ping-ponging and family ganging).

Medically needy: in the Medicaid program, persons who have enough income and resources to pay for their basic living expenses (and so do not need welfare) but not enough to pay for their medical care. Medicaid law requires that the standard for income used by a State to determine if someone is medically needy cannot exceed 133 percent of the maximum amount paid to a family of similar size under the welfare program for families with dependent children (AFDC). In order to be eligible as medically needy, people must fall into one of the categories of people who are covered under the welfare cash assistance programs; i.e., be aged, blind, disabled or members of families with dependent children where one parent is absent, incapacitated or unemployed. They receive benefits if their income after deducting medical expenses is low enough to meet the eligibility standard. Thirty-three States now provide Medicaid coverage to the medically needy.

Notch: a sudden and sharp discontinuity in health or financial benefits for individuals with slightly different income. In certain public and medical assistance programs, an additional dollar of income can mean a total loss of benefits. For example, in Medicaid, families just below the income eligibility standard receive fully subsidized coverage while families with only slightly more income and just above eligibility standards receive no benefits. Substantial incentives for families to restrict their incomes in order to remain eligible may result. Spend down provisions are used to compensate for notches. A notch may also occur when, without change in eligibility, cost-sharing requirements increase suddenly with a small change in income.

Peer Review: generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other practicing physicians or other members of the profession whose work is being reviewed

(peers). Frequently refers to the activities of the Professional Standards Review Organizations (PSRO) which in 1972 were required by P.L. 92-603 to review services provided under the Medicare, Medicaid, and Maternal and Child Health programs. Local PSROs, which receive Federal guidance and funding from HEW, are staffed by local physicians, osteopaths, and non-physicians. Their duties include the establishment of criteria, norms and standards for diagnosis and treatment of diseases encountered in the local PSRO jurisdiction, and review of services that are inconsistent with the established norms, e.g., hospital stays longer than the normal length of stay. The norms may be input, process, or outcome measures. Peer review has been advocated as the only possible form of quality control for medical services because it is said that only a physician's professional peers can judge his/her work. It has been criticized as having inherent conflict of interest, since, it is said, a physician will not properly judge those who will judge him or her, and also as not adequately reflecting patient objectives and points of view.

Prevailing Charge: a charge which falls within the range of charges most frequently used in a locality for a particular medical service or procedure. The top of this range establishes an over-all limitation on the charges which a carrier, which considers prevailing charges in reimbursement, will accept as reasonable for a given service, without adequate special justification. Current Medicare rules state that the limit of an area's prevailing charge is to be the 75th percentile of the customary charges for a given service by the physicians in a given area. For example, if customary charges for an appendectomy in a locality were distributed so that 10 percent of the services were rendered by physicians whose customary charge was \$150, 40 percent by physicians who charged \$200, 40 percent who charge \$250, and 10 percent who charge \$300 or more, then the prevailing charge would be \$250, since this is the level that, under Medicare regulations, would cover at least 75 percent of the cases. See also actual charge.

Professional Standards Review Organization (PSRO): a physician-sponsored organization charged with comprehensive and ongoing review of services provided under the Medicare, Medicaid and Maternal and Child Health programs. The purpose of this review is to determine for purposes of reimbursement under these programs whether services are: medically necessary; provided in accordance with professional criteria, norms and standards; and, in the case of institutional services, rendered in an appropriate setting. The requirement for the establishment of PSROs was added by the Social Security Amendments of 1972, P.L. 92-603, to the Social Security Act as part B of Title XI.

Prospective reimbursement: any method of paying hospitals or other health programs in which amounts or rates of payment are

established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on charge or cost increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs. Prospective reimbursement contrasts with the method of payment presently used under Medicare and Medicaid where institutions are reimbursed for actual expenses incurred, i.e., on a retrospective basis.

Reasonable Cost: generally the amount which a third party using cost-related reimbursement will actually reimburse. Under Medicare and Medicaid, reasonable costs are costs actually incurred in delivering health services excluding any part of such incurred costs found to be unnecessary for the efficient delivery of needed health services. The law stipulates that payments to hospitals shall be made on the basis of the reasonable cost of providing the covered services. The regulations require that costs be apportioned between Medicare beneficiaries and other hospital patients so that neither group subsidizes the costs of the other. The items or elements of cost, both direct and indirect, which the regulations specify as reimbursable are known as allowable costs.

Retrospective Reimbursement: Payment to providers by a third party carrier for costs or charges actually incurred by subscribers in a previous time period. This is the method of payment used under Medicare and Medicaid. See also prospective reimbursement.

Spend-Down: a method by which an individual establishes eligibility for a medical care program by reducing gross income through incurring medical expenses until net income (after medical expenses) becomes low enough to make him/her eligible for the program. The individual, in effect, spends income down to a specified eligibility standard by paying for medical care until his/her bills become high enough in relation to income to allow him/her to qualify under the program's standard of need, at which point the program benefits begin. The spend-down is the same as a sliding scale deductible related to the over-all income level of the individual. For example, if persons are eligible for program benefits if their income is \$200/month or less, a person with a \$300/month income would be covered after spending \$100 out-of-pocket on medical care; a person with an income of \$350 would not be eligible until he/she incurred medical expenses of \$150. The term spend-down originated in the Medicaid program. An individual whose income makes him/her ineligible for welfare but is insufficient to pay for medical care, can become Medicaid-eligible as a medically needy individual by spending

some income on medical care. Medicaid only covers an individual if aged, blind, disabled, or a member of a family where one parent is absent, incapacitated, or unemployed -- that is, fitting one of the categories of individuals who are covered under the welfare cash payment programs.

Third-Party Payer: any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g., Blue Cross and Blue Shield, commercial insurance companies, Medicare and Medicaid). The individual generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on the patient's behalf; such payments are called third-party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

Uniform Cost Accounting: the use of a common set of accounting definitions, procedures, terms, and methods for the accumulation and communication of quantitative data relating to the financial activities of several enterprises. The American Hospital Association, for example, encourages the use of its Chart of Accounts as a system which can be employed by hospitals in the United States.

Usual, Customary and Reasonable Plans (UCR): health insurance plans that pay a physician's full charge if: it does not exceed his usual charge; it does not exceed the amount customarily charged for the service by other physicians in the area (often defined as the 90 or 95 percentile of all charges in the community), or it is otherwise reasonable. In this context, usual and customary charges are similar, but not identical, to customary and prevailing charges, respectively, under Medicare. Most private health insurance plans, except for a few Blue Shield plans, use the UCR approach.

Utilization Review (UR): evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. In a hospital this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a utilization review committee, PSRO, peer review group, or public agency.

Vendor: a provider, an institution, agency, organization or individual practitioner who provides health or medical services. Vendor payments are those payments which go directly to such institutions or providers from a third party program like

Medicaid.

Vendor Payment: used in public assistance programs to distinguish those payments made directly to vendors of service from those cash income payments made directly to assistance recipients. The vendors, or providers of health services, are reimbursed directly by the program for services they provide the eligible recipients. Vendor payments are essentially the same as service benefits provided under health insurance and prepayment plans.

Appendix B - BASIC MEDICAID DATA

Total National Health Expenditures

Billions of Dollars

\$160

140

120

100

80

60

Fiscal
Years

'70

'71

'72

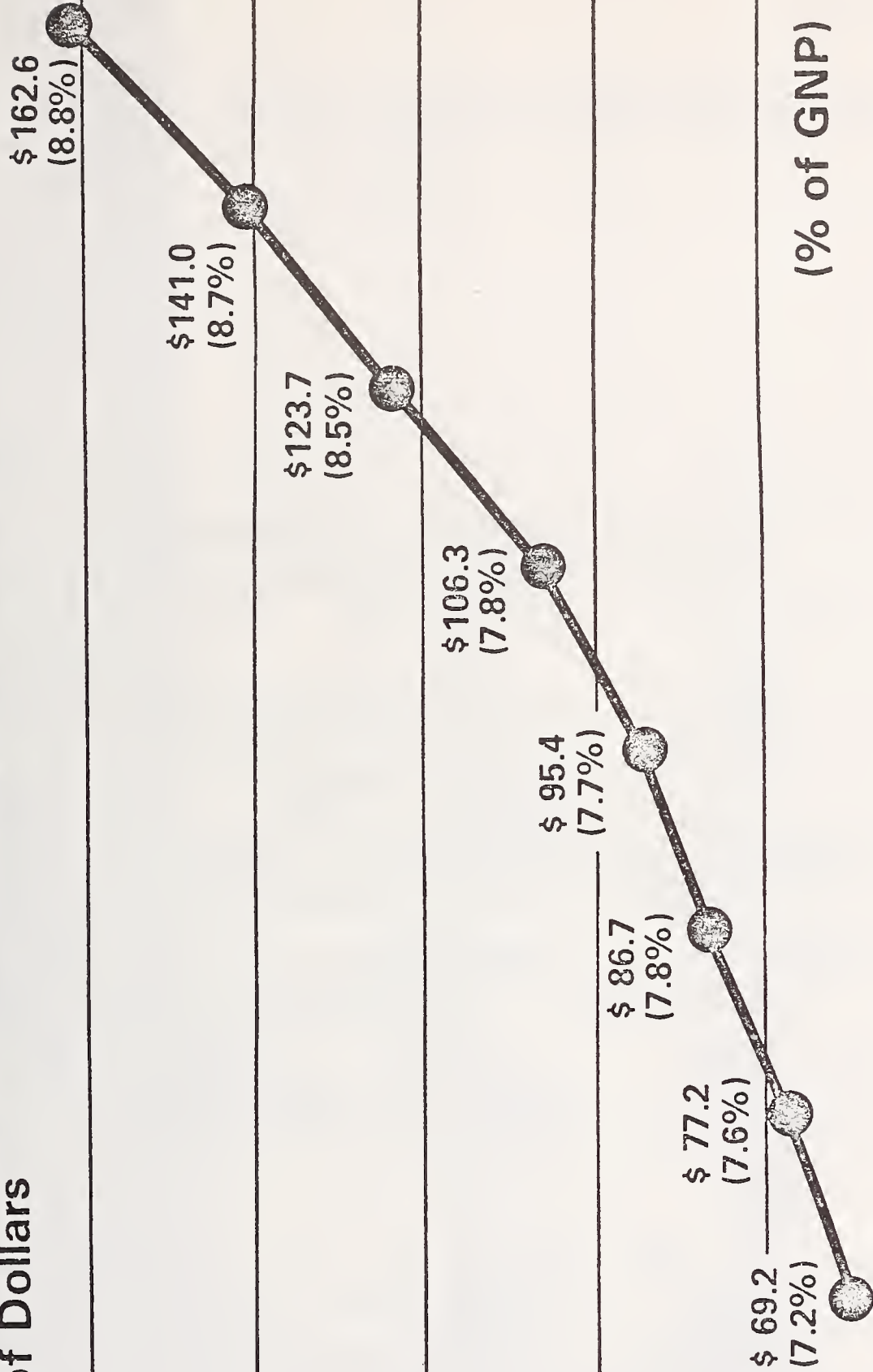
'73

'74

'75

'76

'77



(% of GNP)

***BASIC REQUIRED MEDICAID SERVICES:** Medicaid recipients receiving health clinic services; other laboratory and X-ray services; skilled nursing facility services; planning; and physician services. Federal financial participation is also available for financial assistance. For the latter group States may offer the services required for

Services provided only under 18 vary from State to State. Details are available from local Medicaid agencies. Services under 21 are not shown on this chart.

FMAP ¹		SEE ABOVE	BASIC* REQUIRED MEDICAID SERVICES												Total Additional Services
			Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	
73		Alabama													12
50		Alaska													10
61		Arizona													
72		Arkansas													22
50		California													29
54		Colorado													14
50		Connecticut													24
50		Dalawara													9
50		D.C.													19
57		Florida													9
66		Gaorgia													13
50		Guam													9
50		Hawaii													20
64		Idaho													13
50		Illinois													29
58		Indiana													24
52		Iowa													19
52		Kansas													26
70		Kantucky													17
70		Louisiana													14
70		Maina													22
50		Maryland													16
52		Massachusetts													28
50		Michigan													22
55		Minnsota													31
78		Mississippi													9
61		Missouri													15
61		Montana													26
53		Nabraska													26
50		Navada													20
63		Naw Hampshire													24
50		Naw Jarsay													27
72		Naw Maxico													17
50		Naw York													13
68		North Carolina													19
51		North Dakota													24
55		Ohio													23
65		Oklahoma													10
57		Oragon													23
55		Pannsylvania													14
50		Puerto Rico													13
57		Rhoda Island													10
72		South Carolina													12
64		South Dakota													13
69		Tannassaa													14
61		Texas													10
69		Utah													18
68		Varmont													10
50		Virgin Islands													9
57		Virginia													16
52		Washington													28
70		West Virginia													20
59		Wisconsin													32
53		Wyoming													5
	20		14	13	9	10	5	22	10	1	6	18	17	2	
	33		24	22	17	20	14	25	22	5	12	24	28	9	
Total	53	Total	38	35	26	30	19	47	32	6	18	42	45	11	

¹ FMAP: Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's program as of 3/30/79, are rounded.

² Categorically Needy: People receiving federally supported financial assistance.

³ Medically Needy: People who are eligible for medical but not for financial assistance.

JUNE 1, 1979

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

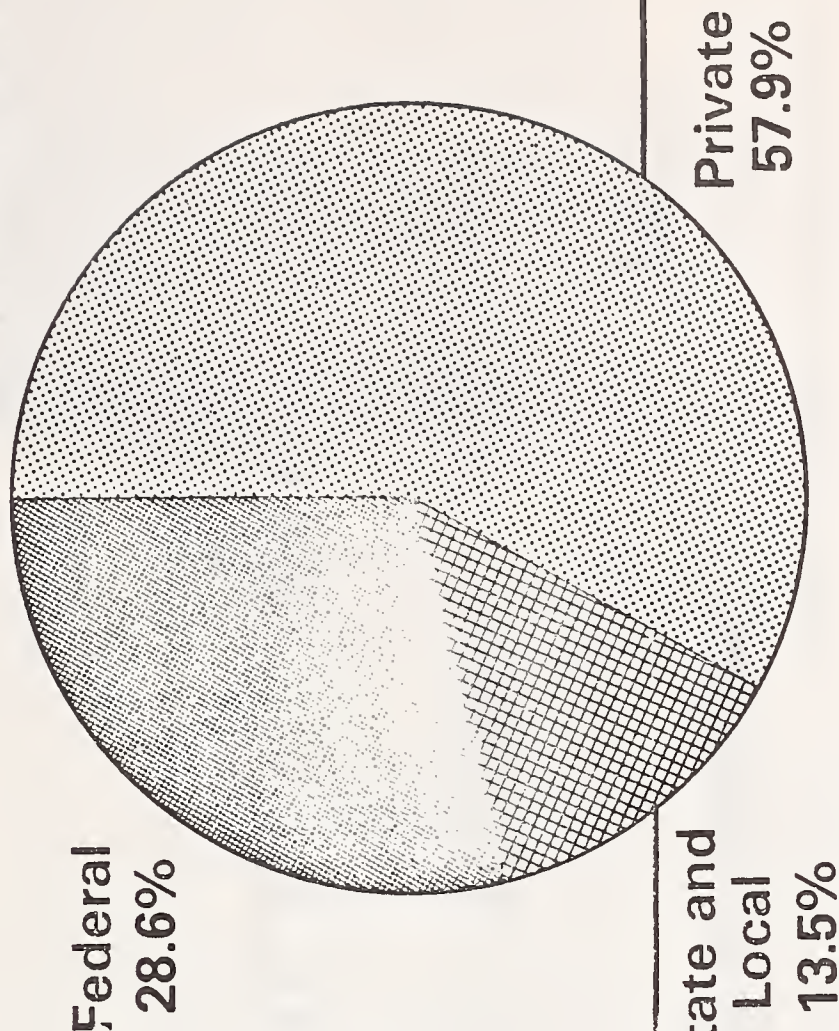
Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

¹ FMAP-Federal Medicaid Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.

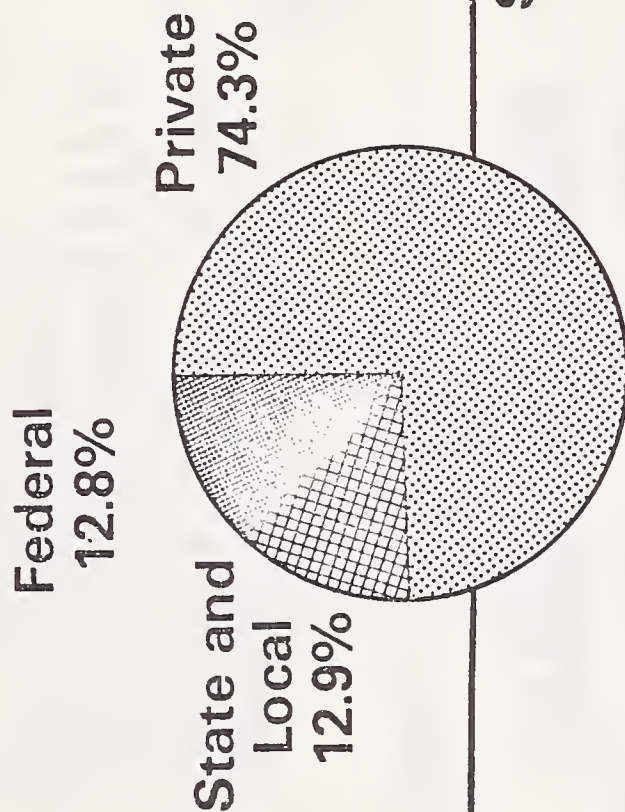
³Medically Needy: People who are eligible for medical but not for financial assistance.

Distribution of National Health Expenditures, by Source of Funds

FY 1977
\$ 162.6 Billion



FY 1966
\$ 42.1 Billion

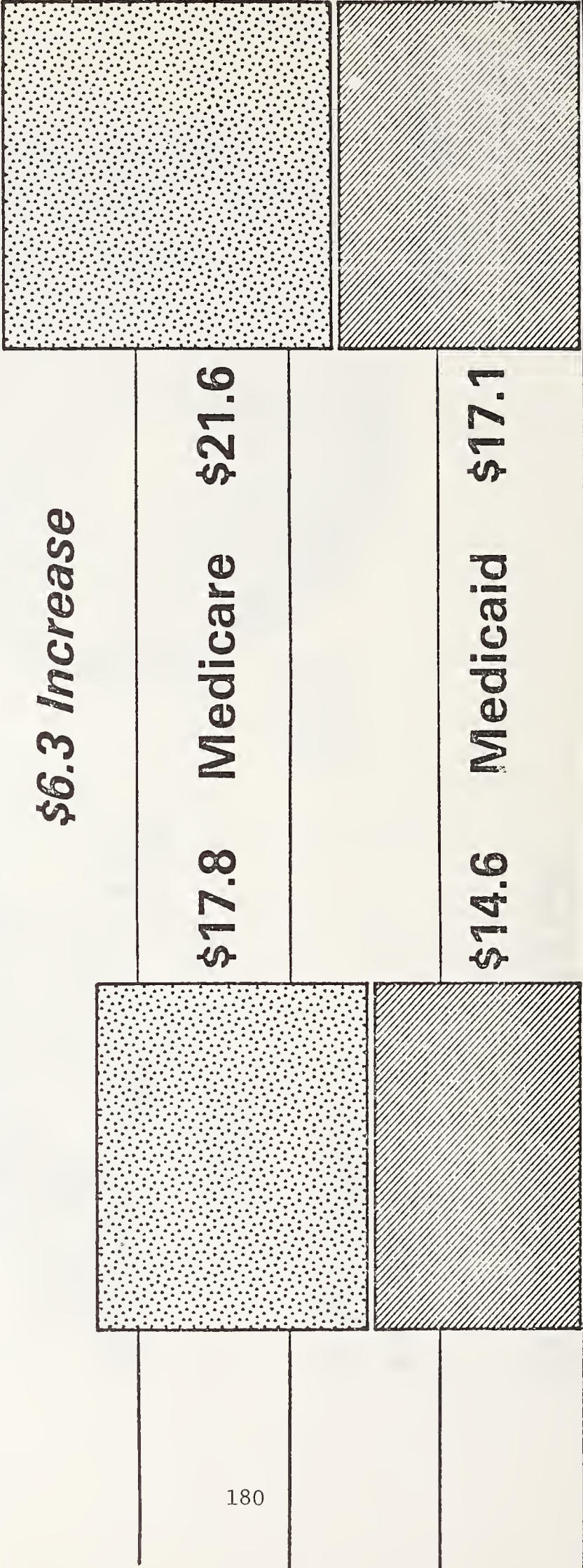


Medicaid and Medicare

Program Costs* (\$ in Billions)

FY 76

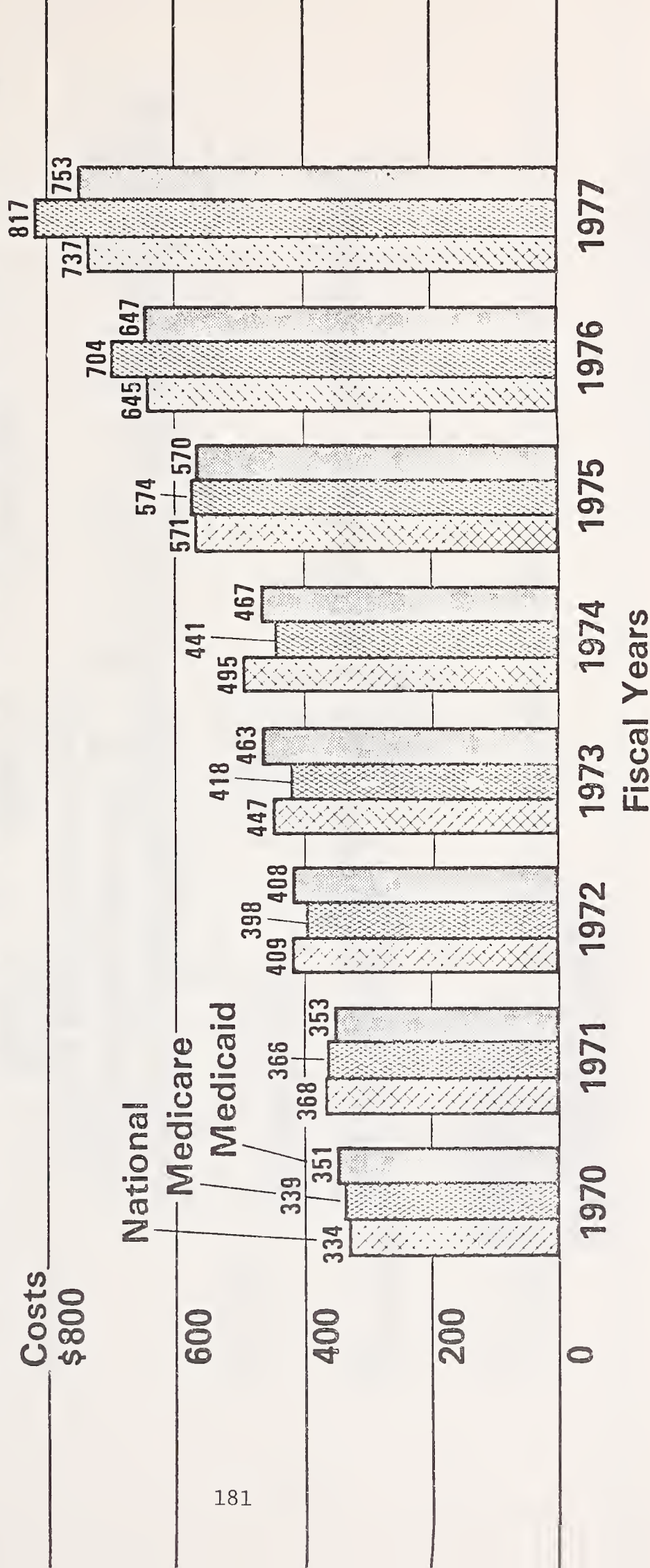
FY 77



* Includes Administrative Expenditures

Comparison of Health Care Expenditures; FY 1970-77

National Per Capita, Medicare Per Enrollee, Medicaid Per Beneficiary



Medicaid:

Eligibility

Who Is Eligible for Federally Assisted Medicaid?

1. Cash Recipients

All AFDC Families

Most SSI Beneficiaries

- Aged
 - Blind
 - Disabled
-

2. Medically Needy (Don't Get Cash)

AFDC-Type Families

SSI-Type Adults

The Medicaid Population

FY 1977

AFDC - 16.1 Million

23.1% Adults

47.7% Children



Aged - 3.7 Million

16.3%



Disabled - 2.8 Million

12.5%



Blind - 98,000

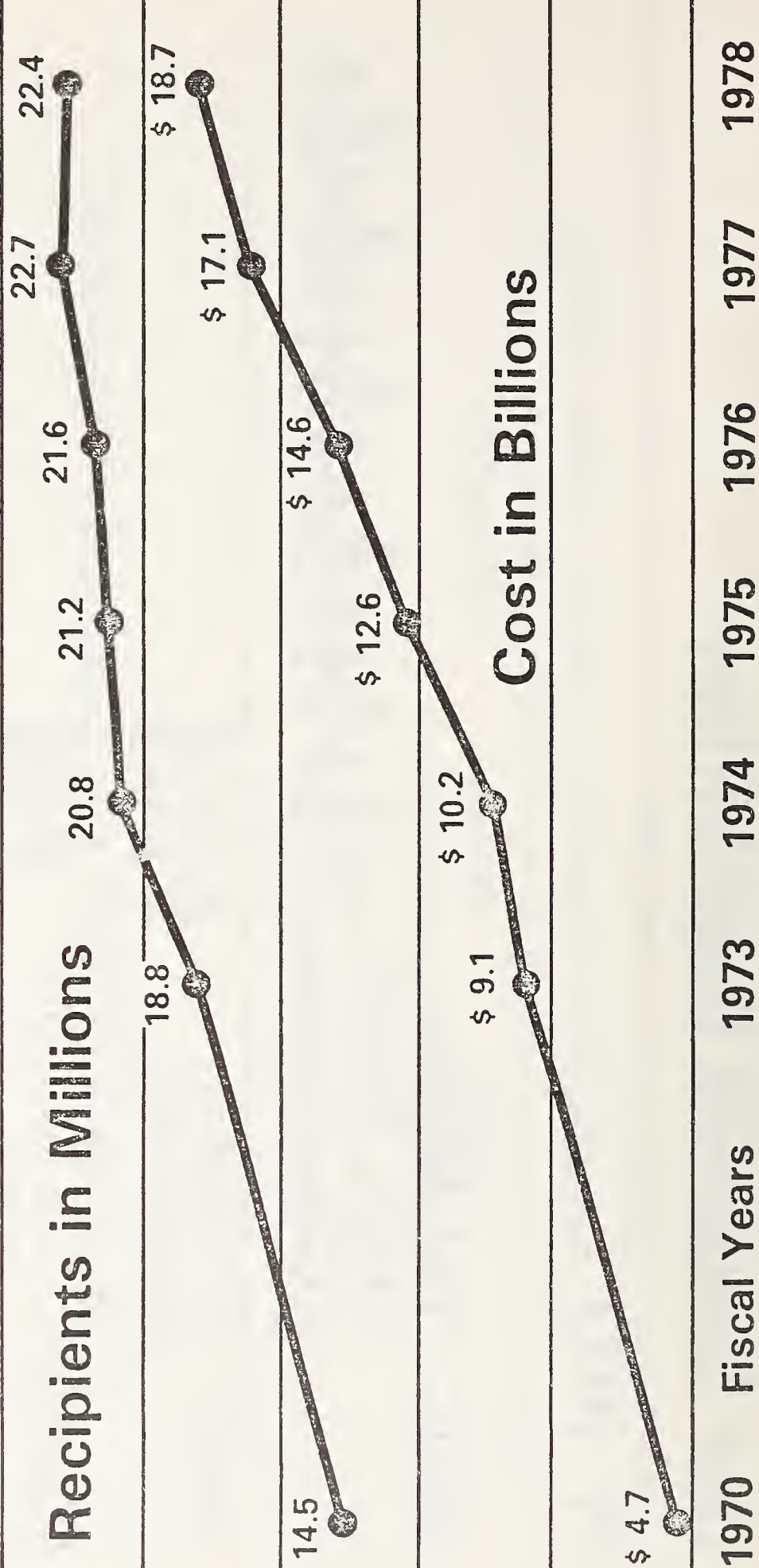
0.4%



Total 22.7 Million


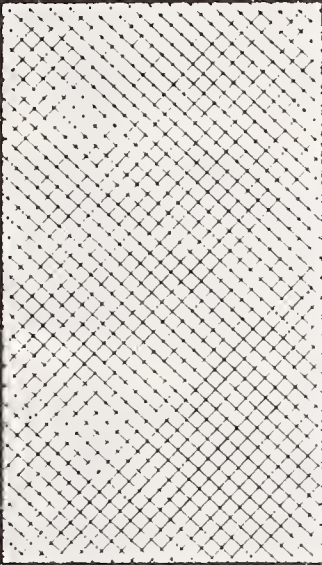



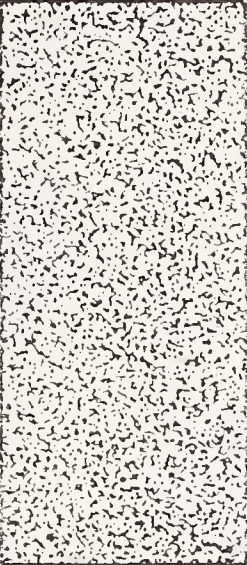


Comparison/Growth:

Medicaid Program Costs and Number of Recipients



Medicaid Patients and Dollars

FY 1977

16%		65 and Over		38%
48%		Children		18%
13%		Blind & Disabled		28%
23%		AFDC Adults		16%

MEDICAID
PATIENTS

EXPENDITURES BY
PATIENT GROUPS

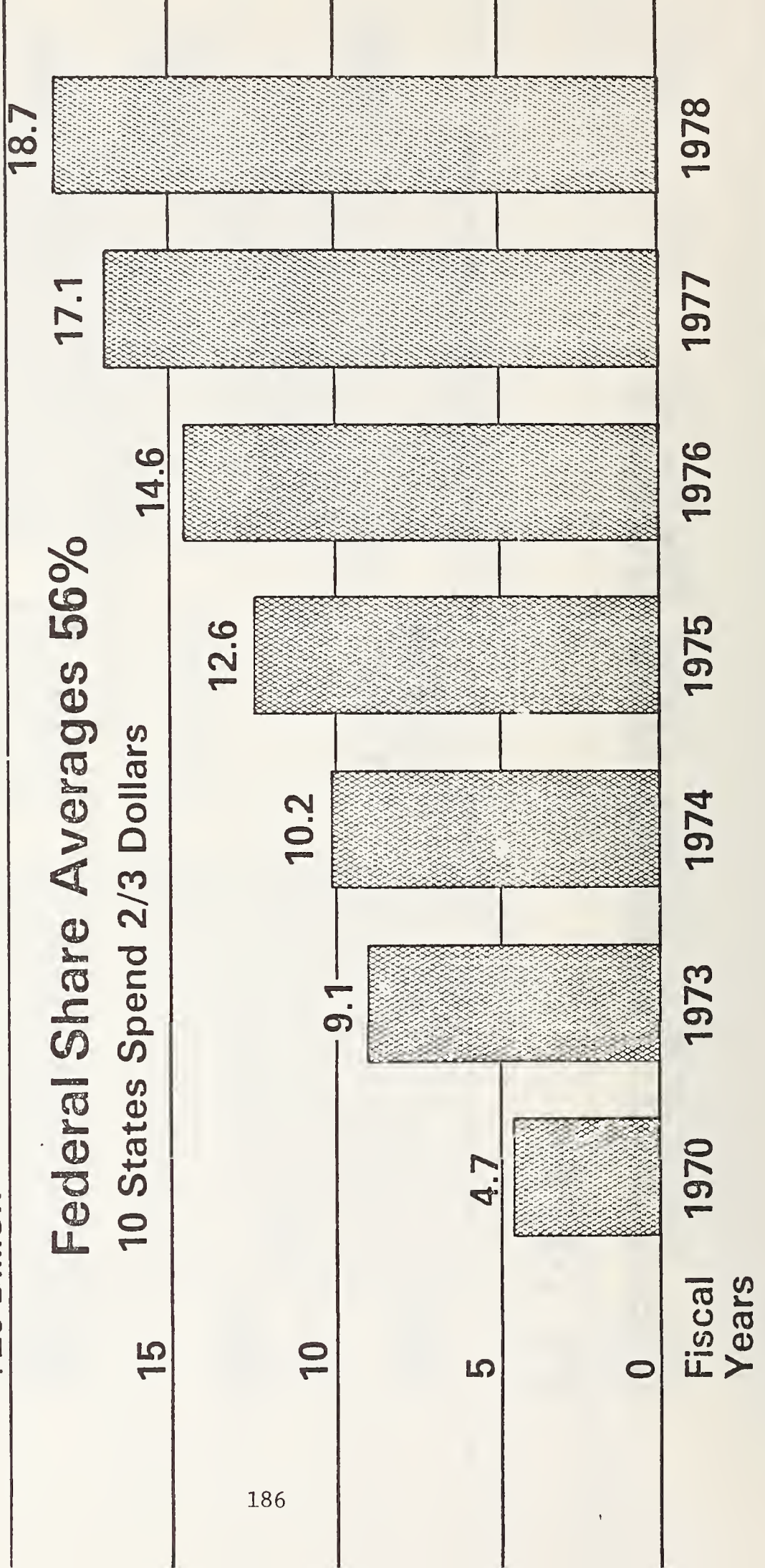
Expenditures

Federal, State, Local

\$20 Billion

Federal Share Averages 56%

10 States Spend 2/3 Dollars



Medicaid Services

Required:

Inpatient - Outpatient Hospital
Physician
Laboratory and X-ray
Skilled Nursing Facility (Over 21's)
Home Health
Family Planning
EPSDT (Under 21's)
Rural Health Clinics

Medicaid Services

Optional:

Rx Drugs

Emergency Hospitals

Dental

SNF's for Under 21's

Physical Therapy

Mental Hospitals for Over 65's

Chiropractors

Mental Hospitals for Under 21's

Eyeglasses

TB Hospitals for Over 65's

Optometrists

Private Duty Nursing

Prosthetic Devices

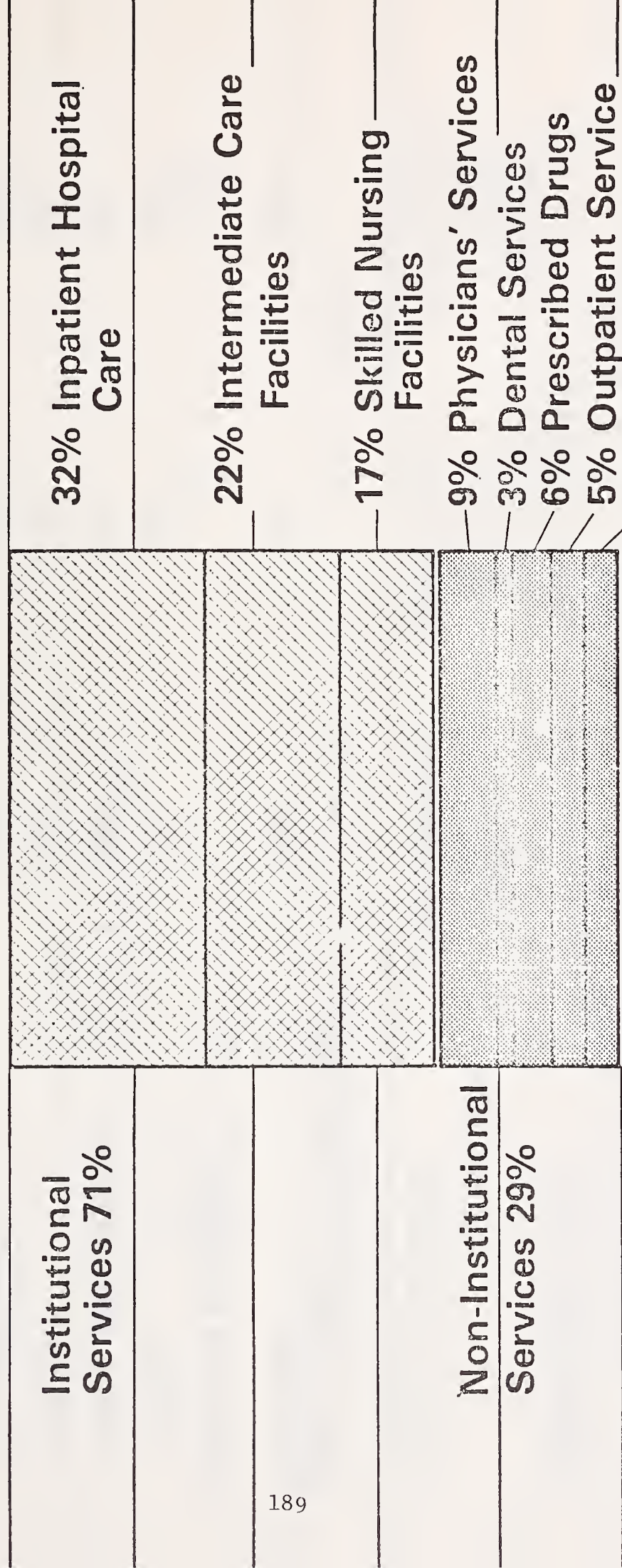
Intermediate Care Facilities

Podiatrists

Other Miscellaneous

Medicaid Services and Funds

(FY 1977)



Expenditures—
by Services

Summary of Medicaid Services and Coverage

December 1977

Types of Services	Number of States Providing Services Only to Categorically Needy Eligibles	Number of States Also Providing Service to Medically Needy Eligibles	Total Number of States Providing Service Under Title XIX
Basic Required Medicaid Services	20	33	53
Optional Services:			
Clinic	13	29	42
Prescribed Drugs	19	32	51
Dental	12	22	34
Eyeglasses	10	25	35
Emergency Hospital	17	26	43
Institutional Services in Intermediate Care Facilities	26	24	50

Impact of Medicaid

Indicators	(Pre-Medicaid) 1964	1976
No. Physician Visits per Person:		
By Poor	4.3	5.6
By Non-Poor	4.6	4.8
% Population with No Physician Visits in Prior 2 Years:		
Poor	27.7	15.1
Non-Poor	17.7	12.9

- 1976 Bureau of Census Estimate: 25 Million in Poverty
- Approximately 70% of Medicaid Population, or 15.1 Million, in Poverty
- 9.9 Million, or 40% Poverty Population, did not receive Medicaid

Appendix C - STATE LEGISLATED COST CONTAINMENT PROGRAMS -- OVERVIEW

State Legislated Cost Containment Programs --
Overview

As of April 1978, fifteen States had enacted legislation which requires the disclosure, review, or regulation of hospital rates or budgets. Significant points include:

- Eight programs are based in independent commissions or boards whose members are representative of various provider or consumer interests.
- Five of these have rate setting commissions with full authority to review and approve hospital budgets or rates.
- Two are authorized to review and comment publicly on the reasonableness of a hospital's costs and charges, either directly or through a designated entity.
- One commission requires only disclosure of hospital financial data.
- Seven programs are based in State agencies.
- Range of authority varies by State.
- Compliance with findings of budget and rate review programs is mandatory in nine programs and voluntary in five.
- The type of rate approved and the extent to which these rates apply to purchasers varies substantially.
- Budget reviews continue to be the predominant method used for determining the reasonableness of costs. However, most programs use an exceptions process to limit reviews to hospitals which exceed the rate of increase in costs or rates of its peer group.

State Legislated Cost Containment Programs -- Three Basic Approaches

Budget Review Approach

Under the budget review approach, the rate-setting body evaluates the projected budgets and schedules of individual hospitals at regular intervals. Rates are set according to adopted guidelines.

The budget review process is premised on the belief that the institution's budget is a means of forecasting, analysis, and control. Regular, in-depth reviews of hospitals' budgets facilitate the rate reviewer's direct influence and participation in the institutional decision making process and allows the rate-setter to consider individual differences among institutions.

Budget Review by Exception

Budget review by exception is an effort at avoiding the need to review every hospital budget in detail. This methodology employs cost and productivity screens to identify those hospitals that appear to exceed established norms. If a hospital exceeds a particular norm, the operating agency must then perform a more detailed budget review.

Prospective Reimbursement by Formula

The formula method places strict controls on rate and cost increases. Some formulas are based on cost functions and point systems that differentiate among individual hospitals by employing select variables from each hospital or by grouping similar hospitals and applying averages or indices to each hospital group.

Other formulas (utilizing averages, indices, or projections of established cost trends) may not account for institutional variation in such areas as case-mix, occupancy, and intensity of care. Allowable rate increases are usually computed annually. They may be calculated by adding a standard percentage to the institutions' base rate or they may be tied to some index that reflects cost increases in the general economy.

Legislation Requiring Review with Mandatory Compliance

State	Type of System	Payers Covered
COLORADO (1977)	Budget/Rate Review and Approval	All payers except Medicare and Medicaid
CONNECTICUT (1974)	Budget/Rate Review and Approval	Charge based payers
MARYLAND (1973)	Budget/Rate Review and Approval	All payers
MASSACHUSETTS (1976)	Contract/Cost/Rate Review and Approval	Blue Cross
	Budget/Rate Review and Approval	Charge based payers
	Rate Setting	Medicaid
NEW JERSEY (1971)	Budget/Rate Review and Approval	Medicaid and Blue Cross
NEW YORK (1969)	Rate Setting	Medicaid and Blue Cross
RHODE ISLAND (1971)	Negotiated Budget/ Rate Review and Approval	Medicaid and Blue Cross
WASHINGTON (1973)	Budget/Rate Review and Approval	All payers
WISCONSIN (1975)	Budget/Rate Review and Approval	All payers except Medicare

Legislation Requiring Review with Voluntary Compliance

ARIZONA (1971)	Budget/Rate Review	Charge-based including Blue Cross
MAINE (1978)	Budget/Rate Review	Charge-based payers
MINNESOTA (1976)	Budget/Rate Review	Charge-based including Blue Cross

OREGON (1977)	Budget/Rate Review	Charge-based including Blue Cross
VIRGINIA (1978)	Cost/Charge Review	Charge-based including Blue Cross

Other Mandatory Programs

CALIFORNIA (1973)	Mandatory Disclosure
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Significant State Legislative Activity in Hospital Cost Controls

State	Nature of Bill Under Consideration
Arizona	To establish a commission
California	For budget/rate review and rate setting
Connecticut	To expand authority to Medicaid
Delaware	Not available
Florida	Not available
Illinois	Rate setting
New Jersey	To expand authority
New York	To expand authority
Rhode Island	To establish a commission

Connecticut

The Connecticut Commission on Hospitals and Health Care was established in 1973 to help stem the rising cost of hospital care. The Commission is empowered to review billed charges for self-pay and commercially insured patients. The Commission also has some measure of indirect control over Blue Cross rates. The basic approach used is budget/rate review and approval.

	Connecticut	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	15.3%	18.9%
1975	14.8%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	15.4%	16.3%
1976	12.9%	13.4%
Inpatient Beds per 1000 Population	4.1	4.5
Occupancy Rate	79.3	74.6
Length of Stay	7.5	7.7
Inpatient Admissions per 1000 Population	134	160
Adjusted Expense per Admission	\$1383	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Colorado

The Colorado State legislature passed a bill in 1977 which established the Colorado Hospital Commission. It is an independent commission composed of three members appointed by the Governor and operates with the Department of Regulatory Agencies. The Commission has the authority to establish rates and issue rules and regulations as necessary for the rate-setting system. All non-Federal hospitals are covered and all payers except for Medicare and Medicaid. The Commission is modelling many of its methods and procedures on those used by the Washington State Hospital Commission. The Commission has just commenced operations and therefore has had no impact so far.

	Colorado	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	21.9%	18.9%
1976	19.4%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	17.4%	16.3%
1976	19.4%	13.4%
Inpatient Beds per 1000 Population	4.2	4.5
Occupancy Rate	71.7	74.6
Length of Stay	6.7	7.7
Inpatient Admissions per 1000 Population	164	160
Adjusted Expense per Admission	\$1034	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Maryland

The Maryland Health Services Cost Review Commission (HSCRC) was established by the General Assembly in 1971. It is an independent commission within the Department of Health and Mental Hygiene, and is composed of seven members appointed by the Governor. The HSCRC began operations in 1974 and was the first hospital rate review agency in the nation to regulate rates for all hospital care. The approach used is budget/rate review and approval.

	Maryland	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	19.5%	18.9%
1976	17.6%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	16.5%	16.3%
1976	14.2%	13.4%
Inpatient Beds per 1000 Population	3.2	4.5
Occupancy Rate	82.4	74.6
Length of Stay	8.5	7.7
Inpatient Admissions per 1000 Population	115	160
Adjusted Expense per Admission	\$1457	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Massachusetts

The Massachusetts State Rate-Setting Commission, established in 1974, is operated by three full time commissioners appointed by the Governor, and employs a staff of 100, including Blue Cross auditors. All payers except Medicare are covered. The Massachusetts Commission is unique in that it utilizes different methodologies for determining the reimbursement rates for different payers. For Medicaid a formula-based rate-setting methodology is used. For Blue Cross the Commission's approach consists of review and approval of proposed contracts between Blue Cross and hospitals, and rates developed under those contracts. For charge payers the approach is budget/rate review and approval.

	Massachusetts	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	16.2%	18.9%
1976	13.0%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	15.6%	16.3%
1976	13.7	13.4%
Inpatient Beds per 1000 Population	4.5	4.5
Occupancy Rate	79.3	74.6
Length of Stay	8.5	7.7
Inpatient Admission per 1000 Population	152	160
Adjusted Expense per Admission	\$1700	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

New Jersey

New Jersey was among the first States to limit reimbursement paid to hospitals. In 1958, the Commissioner of Insurance imposed ceilings on Blue Cross rates of payment. The New Jersey legislature passed the Health Care Facilities Planning Act in 1971; it centralized under the State Department of Health the power to license, grant certificates of need, and regulate all aspects of the hospital industry. The law resulted in a mandatory prospective rate system.

	New Jersey	U.S.A.
Percentage increase in Inpatient Expenses		
1975	17.9%	18.9%
1976	15.0%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	13.6%	16.3%
1976	14.5%	13.4%
Inpatient Beds per 1000 Population	4.1	4.5
Occupancy Rate	82.1	74.6
Length of Stay	8.8	7.7
Inpatient Admission per 1000 Population	139	160
Adjusted Expense per Admission	\$1254	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

New York

New York State's cost containment program was first implemented in 1970. It is operated by the New York State Office of Health Systems Management, and was the first prospective payment system in the nation to set rates solely on the basis of statistical formulas with no retroactive adjustment.

	New York	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	19.2%	18.9%
1976	10.0%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	18.6%	16.3%
1976	9.6%	13.4%
Inpatient Beds per 1000 Population	4.7	4.5
Occupancy Rate	85.4	74.6
Length of Stay	9.9	7.7
Inpatient Admissions per 1000 Population	148	160
Adjusted Expense per Admission	\$1673	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Rhode Island

The Rhode Island hospital cost containment system was initiated in July 1971. It utilizes a negotiated budget approach and covers Blue Cross and Medicaid. Negotiations are conducted between the staff of Blue Cross, the State Budget Office, and the Hospital Association of Rhode Island to set a Maxicap, the maximum percentage increase in total hospital expenditures allowed in the State during the coming year. Subsequently, hospital budget negotiations are conducted between the staffs of Blue Cross and the State Budget Office (jointly referred to as the Third Parties) and the hospitals.

	Rhode Island	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	20.8%	18.9%
1976	11.9%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	15.1%	16.3%
1976	15.1%	13.4%
Inpatient Beds per 1000 Population	3.8	4.5
Occupancy Rate	82.1	74.6
Length of Stay	8.2	7.7
Inpatient Admissions per 1000 Population	137	160
Adjusted Expense per Admission	\$1487	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Washington

The Washington State Legislature approved legislation in 1973 to establish a State Hospital Commission to lessen the pace of hospital cost inflation. The Commission is an independent agency and has five members. It is empowered by statute to review projected annual revenues and approve the reasonableness of rates. A uniform system of reporting was developed by the Commission and is presently in use by all hospitals in the State.

	Washington	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	20.9%	18.9%
1976	16.0%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	20.3%	16.3%
1976	16.0%	13.4%
Inpatient Beds per 1000 Population	3.3	4.5
Occupancy Rate	66.8	74.6
Length of Stay	5.6	7.7
Inpatient Admissions per 1000 Population	146	160
Adjusted Expense per Admission	\$983	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Wisconsin

The Wisconsin Hospital Rate Review Committee was established in 1975. It has 20 members chosen by the Governor, Blue Cross, and the State hospital association. All payers except Medicare are covered. The approach used is budget/rate review and approval. Actual budget analysis is performed by the staff of Blue Cross, and technical support for developing methodology is provided by the staff of the Department of Health and Social Services. Final authority to decide on the reasonableness of rates rests with the Rate Review Committee.

	Wisconsin	U.S.A.
Percentage Increase in Inpatient Expenses		
1975	15.6%	18.9%
1976	18.4%	14.8%
Percentage Increase in Inpatient Expense per Admission		
1975	15.1%	16.3%
1976	18.9%	13.4%
Inpatient Beds per 1000 Population	5.3	4.5
Occupancy Rate	70.6	74.6
Length of Stay	8.4	7.7
Inpatient Admissions per 1000 Population	162	160
Adjusted Expense per Admission	\$1115	\$1169

Note: The source for all figures is the American Hospital Association. All figures are for 1976 unless otherwise noted.

Appendix D - Medicaid Quality Control System

Medicaid Quality Control System*

On April 1, 1978, Federal regulations were issued which required each State Medicaid agency to implement a revised Medicaid Quality Control (MQC) system. The purpose of the new MQC system is:

- to examine a statistical sample of Medicaid cases to determine:
 - what percent are eligible and ineligible
 - how much money was incorrectly paid out for
 - ..ineligible recipients
 - ..unrecovered third party insurance
 - ..claims processing errors
- to identify the reasons for errors so that corrective action and error reduction programs can be implemented.

I will begin with a brief overview of the Medicaid Quality Control system -- what it is, how it operates, some of its problems, the kinds of benefits or payoffs the system offers and what the roles of the State legislators might be in helping us solve some problems.

First, a brief status report would be helpful. It is clear that a very sharp growth has occurred in the Medicaid program in the last seven years: recipients have increased by about 60 percent to 23.5 million persons. This growth averages out to about a million and a half new persons being added to the Medicaid program on an annual basis; expenditures have increased over 300% to \$18 billion or an average increase of \$1.5 billion per year.

It was practically inevitable that under conditions of such rapid growth, normal management and fiscal control systems would be overwhelmed -- in fact, would collapse -- and that the level of recipient ineligibility and provider fraud and abuse would increase.

* These remarks were made by Victor Kugajevsky, then Deputy Director of Financial Management, Medicaid Bureau, before the State Legislators Conference in Denver, Colorado, on March 12, 1977. Some editorial changes have been made for publication purposes.

Indeed, management controls did collapse. The mass media has been reporting extensive fraud and abuse, ranging from things like recipient dishonesty where false statements about income or resources are given in order to qualify for Medicaid coverage, to administrative failures on the part of the agencies running these programs in terms of not being able to take ineligibles off the rolls early enough and recalling their Medicaid cards. As a result a person who is ineligible this month may continue to carry and illegally use a valid Medicaid card for the next year or so.

How bad is the problem? Some preliminary audits by the General Accounting Office have shown that in several States the rates of recipient ineligibility have run as high as 28 percent. At these levels of ineligibility, over a billion dollars of Medicaid funds are misspent each year for Medicaid coverage for people who do not qualify.

In order to check this problem, we instituted a three-fold management control effort in the Medicaid program, corresponding to the three segments of the Medicaid program.

First, there is client intake. That is what the old Medicaid Quality Control program was principally focused on. Next is the utilization control, designed to control the appropriateness of the services. And last is provider fraud and abuse control programs.

Essentially, Medicaid Quality Control began as a front-end kind of program. It tried to insure that the people getting into the program were eligible. The first version of Medicaid Quality Control was to be implemented by each State as of June, 1975. That is when the regulations requiring each State to implement the program went into effect. The purpose of the program was essentially three-fold:

1. to provide State Medicaid program administrators an accurate measure of ineligibility error rates;
2. to provide information on what are the causes for these errors; and
3. to identify the best ways or corrective actions to rectify or eliminate these errors.

The early version of the Medicaid Quality Control program covered essentially the "medically needy" segment of the Medicaid population. That segment accounts for 34 percent of the recipients and approximately 55 percent of Medicaid expenditures. The reason the other two segments of the Medicaid population (AFDC and SSI) are not covered by the Medicaid Quality Control program is because these segments were covered by the AFDC & SSI Quality Control

programs.

How does Medicaid Quality Control work? Basically, the program is based on a long-established "quality control" system concept used throughout American industry. Under these "QC" systems, the quality or accuracy of products or services is examined. This is done by taking a statistical sample that is representative of the total universe being considered. By examining this sample we know what the quality of products is in the total production flow. In the early version of Medicaid QC, 18,000 claims were reviewed by States every 6 months to determine whether a person for whom that claim was paid was eligible. There is a Federal re-review of a sub-sample of 3500 claims of those 18,000 claims, to verify the accuracy of the State reviews. The results of these reviews produce the final information on ineligibility error rates in each State's Medicaid program. These rates are used to identify the amount of erroneous expenditures being caused by ineligibles who are receiving Medicaid coverage, what the concentrations of these errors are in terms of such things as whether they arise primarily out of institutional or noninstitutional sources, and what kind of corrective actions need to be taken in order to eliminate the sources of these ineligibility errors. Then a corrective action plan is developed that the State is expected to implement, to correct these problems. HEW provides technical assistance to States in the design and implementation of the corrective action plan.

The last component of the Medicaid QC program is reporting. Reports are very simple in this program. There is a periodic statistical report where every six months the State reports its error rate results and there is a State corrective action plan where the State identifies what kind of actions it will undertake to remedy the eligibility problems that have been identified.

HEW issued a regulation in July, 1975, requiring States to implement this QC program. Many States did not implement the program. The chart following this page shows, for one 6 month period, which States did and did not implement the QC program. In essence, the QC program had not been implemented nationwide and certainly not in those States that generate the high levels of Medicaid expenditures.

What are some of the preliminary results that have been achieved in the program to date? Those States that have successfully implemented the program have begun to identify some causes of eligibility errors, and have begun to take the kinds of corrective actions required to begin remedying these errors. HEW is also undertaking some efforts to make the whole eligibility process less complicated and less confusing. We are suggesting modifications in the legislation. We are simplifying various

regulations, and simplifying the whole eligibility determination process. We have established something called the Institute for Medicaid Management which will begin collecting, and then disseminating to State "how-to-do-it" publications on "best practices" techniques for reducing errors.

What this Institute will do is collect proven techniques for reducing errors and then disseminate them to other States and coordinate technical assistance that would provide direct advice to States on how to use these proven techniques for reducing errors.

Why is Medicaid Quality Control important for States? Basically, there exists a powerful cost benefit leverage in the program. If all States implement the program, the direct costs will be the following: around five hundred staff persons will be required nationwide - ninety Federal and four hundred and ten among the States. The total cost of these staff would be at least of this order: assuming that there would be the same rate of improvement as States have made in reducing AFDC ineligibility errors through the AFDC Quality Control Program, around 20 percent a year, States could save, nationwide, \$190 million per year that is currently being lost on ineligibles in their various Medicaid programs. Overall, as shown in Figure 1, the total estimated loss in dollars (July, 1977) for payments for medical services to ineligibles is over a billion dollars. Of this about \$187 million derives from ineligibles in the AFDC segment of the program and around \$150 million for ineligibles flowing into the Medicaid program from the SSI program.

In short, given the magnitude of this dollar loss, there should be ample reason for every State to vigorously implement the Medicaid Quality Control program, particularly so since half the money is State funds and most States have proven in the AFDC program that ineligibility errors can be reduced.

What are some of the problems standing in the way of implementing the programs? They are essentially three-fold. Some States lack commitment to the Medicaid Quality Control program. They simply have not allocated the handful of staff positions required to implement it.

Secondly, State administrators, health and welfare, and umbrella agency administrators, lack the sort of fiscal penalty leverage to get the required staff from State legislatures for implementing Medicaid Quality Control. In AFDC, with the threat of a fiscal penalty, all States implemented the AFDC QC program almost overnight, once the Federal government announced its planned fiscal penalty. Such fiscal penalties are not now in the MQC program, which makes it difficult for Medicaid program administrators to convince their State legislatures and their governors that the

**TOTAL MISSPENT DOLLARS \$1.21 BILLION (FY 77)
 FY '77 ELIGIBILITY PAYMENT ERROR 7.0%**

<p>\$187 MIL</p> <p>MISSPENT DOLLARS</p>	<p>AFDC* NOT NOW SUBJECT TO MEQC REVIEW</p> <p>4.0% INELIGIBILITY ERROR RATE</p> <p>12.5 MILLION RECIPIENTS</p>
<p>\$882 MIL</p> <p>MISSPENT DOLLARS</p>	<p>MEDICALLY NEEDY + SOME SSI SUBJECT TO MEQC REVIEW</p> <p>8.4% INELIGIBILITY ERROR RATE</p> <p>9.5 MILLION RECIPIENTS</p>
<p>\$150 MIL</p> <p>MISSPENT DOLLARS</p>	<p>SSI** 4.9% INELIGIBILITY ERROR RATE</p> <p>5.5 MILLION RECIPIENTS</p>

*ASSUMES 1/4 OF ALL AFDC INELIGIBLES ARE ELIGIBLE FOR MEDICAID THROUGH SPEND-DOWN PROVISIONS. THE AFDC AVERAGE INELIGIBILITY RATE FOR THE COMPARABLE PERIOD IS 5.3%

**ASSUMES 1/4 OF ALL SSI INELIGIBLES ARE ELIGIBLE FOR MEDICAID THROUGH SPEND-DOWN PROVISIONS. THE SSI ERROR RATE FOR THE COMPARABLE PERIOD IS 6.5%.

program needs to be implemented.*

The third set of problems dealt with technical defects in the OC system. The early version of the OC focused only on measuring eligibility errors for a segment of all Medicaid recipients. This left a large slice of the Medicaid population uncovered by OC, and many errors unmeasured. In summer, 1977, HEW began working with States to revise the OC system. This has been completed and a new OC system was developed; States were required to implement it starting April 1, 1978. The new OC system for Medicaid has several key features including:

- a nationwide sample of 77,000 cases that cover the total Medicaid population
- each State has a sample that is statistically representative of its Medicaid population
- the OC system measures the amount of Medicaid funds that are misspent on 3 types of errors--
 - ineligible recipients
 - unrecovered third party liability (TPL) (Medicaid recipient has other health insurance that should pay for his medical expenses) and
 - claims processing (CP) errors (claims paid for unallowable services, above State fee schedule, etc.).

All States should be operating this new OC system.

While implementing the new OC system will inherently improve management control of Medicaid, a much more urgent reason to implement and apply the OC system is the excessively high level of misspent Medicaid funds. In 1977, over 12% of Medicaid's funds were misspent on ineligibles, TPL and CP errors. The table following this page shows HEW's estimate of the level of misspent funds in each State. Implementing the new OC system will do two things for each State:

* On July 7, 1978, HEW issued a notice that it was planning to adopt a similar fiscal penalty policy under which States that failed to reduce eligibility errors to a preset "tolerance" would lose some Federal funds. This regulation was published in final on March 7, 1979.

FY 1976 ESTIMATED MEDICAID LOSSES DUE TO
INELIGIBILITY, THIRD PARTY LIABILITY, AND CLAIMS PROC ERRORS

State	FY 76 Payments (000)	MQC Error Rate	MQC Dollar Loss	AFCU Error Rate	Medicaid Loss Due to MQC	TPL Loss	QPE Loss	Total Loss ¹⁾ (000)	State Share (000)	Federal Share (000)	MQC Staff	MQC Staff Cost (000) L ²
Alabama	170,032	4.0	1835	4.6	1467	6121	2040	11,463	3063	8400	8	121,600
Alaska	12,269	8.2	843	9.3	214	442	147	1,676	815	881	3	45,600
Arizona	128,026	5.1	2375	4.5	1080	4609	1526	9,600	2632	6968	7	106,400
California	1,773,464	4.3	45,096	2.4	7981	62,845	21,282	138,204	68,816	69,388	31	471,200
Colorado	111,899	4.1	32,662	4.6	465	4048	1345	4,336	2,867	6,369	7	106,400
Connecticut	193,004	24.7	18,704	5.1	1846	6948	2316	43,712	23,044	21,728	8	124,600
Delaware	18,677	4.1	164	5.7	200	672	224	1,260	544	716	4	60,500
Dist. of Col.	101,704	44.0	5806	15.4	2937	3661	1220	12,624	6,429	7,195	10	152,000
Florida	189,313	1.8	1170	4.5	1547	6815	2272	11,854	5,168	6,686	48	729,600
Georgia	267,648	11.2	13,218	10.5	5269	9635	3212	31,334	10,710	20,624	16	243,200
Hawaii	44,917	4.4	914	2.5	547	1617	539	3,687	1790	1897	9	134,100
Idaho	31,366	10.0	3121	0.7	42	1151	384	4,698	1509	3,189	3	45,600
Illinois	766,165	4.1	15,527	8.1	11,636	27,582	9194	63,939	30,700	33,239	21	319,200
Indiana	207,792	1.6	2,552	1.3	506	7481	2494	12,733	5457	7,282	19	148,100
Iowa	123,084	5.1	3154	6.3	1454	4431	1477	10,516	4816	6015	6	91,200
Kansas	111,978	5.3	4547	3.5	735	4031	1344	10,657	4816	5841	6	91,200
Kentucky	150,432	7.0	1673	5.4	1523	5415	1805	10,416	2796	7620	18	279,600
Louisiana	197,067	7.2	5045	5.0	1848	7094	2365	16,352	3979	12,373	10	152,000
Maine	74,269	13.2	4072	10.3	1434	2674	891	9,071	2458	6,613	8	121,600
Maryland	241,365	14.6	17,814	8.2	3711	8689	2826	23,110	16,067	7,043	16	243,200
Massachusetts	619,746	12.5	48,520	8.1	9412	32,311	7437	81,750	39,057	42,693	16	243,200
Michigan	739,213	7.3	28,536	4.8	6653	26,612	8871	70,674	34,577	36,097	42	638,400
Minnesota	318,058	3.8	10,772	2.9	2332	11,479	3826	28,409	12,254	16,155	9	136,800
Mississippi	118,633	1.1	6780	6.5	1446	4432	1424	13,921	2713	11,208	23	342,600
Missouri	123,123	5.9	7544	7.9	1824	4472	1477	15,277	6218	9059	15	223,200
Montana	31,241	9.2	5380	3.9	238	1135	375	7,108	2617	4491	10	152,000
Nebraska	58,881	6.8	2524	4.9	541	2120	707	5,892	2491	3401	4	60,800
Nevada	33,039	3.5	950	0.6	26	829	276	2,081	1030	1051	3	45,600
New Hampshire	34,087	3.5	715	3.5	224	1227	409	2,575	1012	1522	10	152,000
New Jersey	392,648	20.2	2824	3.1	220	1261	454	2,247	11850	12,453	12	182,400
New Mexico	37,813	2.7	212	9.0	48922	106,499	35,500	366,690	179,248	187,442	39	592,800
New York	2,958,316	11.1	174,767	4.4	1651	7205	2402	20,010	4687	15,323	17	258,400
North Carolina	200,146	4.1	8752	3.6	125	922	307	1,507	654	853	3	45,600
North Dakota	25,602	0.7	153	7.8	6534	16132	5378	86,735	38,864	47,871	17	258,400
Ohio	418,150	18.9	58,670	2.1	64	5857	1952	11,982	3919	8063	9	126,800
Oklahoma	162,688	2.5	3522	4.6	843	3520	1173	7,664	2913	4751	7	106,400
Oregon	97,772	2.0	2128	4.6	7713	23,139	7713	60,555	23,384	38,171	24	364,800
Pennsylvania	642,746	6.5	21,970	6.4	7713	23,139	7713	60,555	23,384	38,171	24	364,800
Puerto Rico	67,445	15.0	5294	5.1	645	2430	510	9,179	5430	3,749	14	212,400
Rhode Island	86,796	6.5	5294	3.9	618	3125	1042	4,785	1917	2868	9	136,800
South Carolina	107,486	13.2	4436	4.9	988	2869	1290	10,583	2934	7649	10	152,000
South Dakota	25,716	10.5	1425	2.3	159	926	309	2,816	897	1919	6	91,200
Tennessee	188,032	6.3	2843	5.7	2010	6769	2256	14,878	4220	10,658	30	456,000
Texas	631,050	6.6	16,826	2.3	3905	23,718	7573	51,032	18655	32,377	24	364,800
Utah	40,726	6.0	1670	4.1	313	1466	489	5,693	1198	2740	5	76,000
Vermont	37,457	17.4	3566	4.7	320	1348	449	5,693	1477	4216	5	76,000
Virgin Islands	6,200	36.1	254	11.0	37	47	16	372	131	241	2	30,400
Virginia	182,446	7.8	10,412	5.1	1745	6565	2189	20,914	8111	12,803	17	238,400
Washington	173,125	2.1	1579	3.5	1136	6233	2078	11,026	4877	6149	12	152,400
West Virginia	64,263	11.3	2062	2.7	311	209	736	5,318	1467	3851	7	106,400
Wisconsin	418,016	3.3	162	1.8	1411	45,049	5016	21,416	8608	12,808	11	162,200
Wyoming	6,659	3.3	240	3.2	40	240	80	522	205	319	3	45,600
TOTAL	12,977,308		591,156		153,468	503,184	164,730	1,416,245	624,298	791,950		

1) MQC DATA NOT REPORTED IN EITHER PLP100
2) MQC DATA REPORTED ONE PERIOD ONLY - USED FOR BOTH

3) BASED ON NATIONWIDE AVERAGE OF \$15,100 PER PERSON
4) EXCLUDES DATA FOR 1934 CONTRACT STATES

- provide a precise measure of the level of misspent funds, and
- provide the basis for reducing this waste.

HEW is urging States to apply the QC system to their Medicaid programs. Beyond this HEW also is doing several other things in the QC area:

- national targets have been set for reducing the level of erroneously spent Medicaid funds
- special briefings for governors and State legislators are being scheduled to inform them of this error reduction effort.

In addition HEW is seriously trying to look at the Federal legislative and regulatory causes of errors, and attempting to eliminate those, by simplifying regulations, and by clarifying conflicts.

A stepped up public affairs campaign is being planned by HEW to make the general public more aware of what is happening in the Medicaid program, how much money is being lost, and where different States are in terms of implementing the Medicaid Quality Control.

What also is needed is for State legislators to take the time out of their busy schedules to pay a little more attention to the Medicaid program. Secondly, legislators should sit down with the Medicaid administrators in each of their States and find out what they are doing with the QC system to get a handle on controlling the high levels of erroneous expenditures for ineligibles. Thirdly, legislators should set some goals against which those administrators can be held accountable. And lastly, legislators should provide the kind of resources that will be needed to get this program going.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
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